Jeremy R. Watson DDS, MS 1248 East 90 North Suite 201, American Fork, UT 84003

# ORTHODONTIC HEALTH HISTORY FORM

Date: _____

Patient's Name:_____ Name they would like to be called:_____

Birth Date:_____ Age:_____ Sex: Male ☐ Female ☐ Names/ ages of siblings:_____

_____

Home Phone #:_____ Cell #:_____ Work #: _____

E-Mail Address:_____

Mother's Name:_____

Father's Name:_____

Father's Employer:_____ Work Phone #:_____ Mobile Phone#:_____

Who has legal custody of patient?_____ Patient lives with (Circle all that apply) Mother Father Both Other_____

Child's Dentist:_____ Phone:_____ Date of last exam:_____

Whom may we thank for referring you to us?_____

What is the reason for today's visit?_____

Person financially responsible for this account:_____ Insurance coverage for Orthodontic treatment? Y N

Primary Policy Holder Name:_____ Insurance Company Name and Address:_____

ID#_____Birth Date:_____Group #_____

Secondary Policy Holder Name: _____ Insurance Company Name and Address:_____

ID#:_____ Birth Date:_____ Group #_____

Did your dentist recommend orthodontic treatment? Y N

## PATIENT PROFILE

Is the patient concerned with the appearance of the smile?_____

Why do you think orthodontic treatment is needed?_____

Has there been any prior orthodontic treatment or appliances?_____

Is there any information that would help us better treat the patient?_____

## HEALTH HISTORY

**YES NO**

____ ____ Has your child ever had a health problem? Please explain_____

____ ____ Has your child ever been hospitalized? Please give reason and dates_____

____ ____ Is your child allergic to anything? _____

____ ____ Is your child currently taking any medications? Please give medication and reason_____

____ ____ Were there any problems at birth?_____

**Please chick if your child has been treated for any of the following:**

___Heart disease ___Lever diseases ___Kidney disease ___Bleeding/transfusion ___Asthma

___Anemia ___Rheumatic fever ___Seizures ___Diabetes ___Hepatitis

___Cerebral palsy ___Cleft lip/palate ___AIDS ___Depression ___ADHD/ADD

___Learning Disability ___Speech/hearing ___Other Problems (Please explain)_____

## DENTAL HISTORY

**YES NO**

____ ____ Does your child suck a finger, thumb or pacifier?

____ ____ Does your child have pain with chewing, yawning or wide opening?

____ ____ Does your child's jaw make noise and is pain associated with the sounds?

Have there been any accidents or trauma to the teeth or face?_____

Are there any teeth missing?_____

Have any teeth been removed?_____

Are there any other dental conditions or problems that we should be aware of?_____

## CONSENT OF DENTAL TREATMENT

I request and authorize Dr. Watson to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Watson to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age.

Signature_____Relationship to patient_____Date_____

## PAYMENT POLICY

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to Dr. Watson My account can be turned over to a collection agency. Dr. Watson will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature_____Relationship to patient_____Date_____