Shoff Orthodontics - For patients under 18

PATIENT INFORMATION - Who may we thank for referring you to our office: ____
Have any other family members been treated in this office? Please list them ____

First Name________________________Last Name_______________________Middle Initial______Age______Gender_____

Address_______________________________________City_____________________________State/Zip______________

Date of Birth_______________SS #: __________________________Grade______School attending_____________________

PARENT/GUARDIAN: Patient lives with (check all that apply) □ Mother □ Father □ Stepmother □ Stepfather □ Grandparent (s) □ other

FATHERS NAME: First Name___________________________ Last Name__________________________ Middle Initial____

Address_________________________________City______________________State______Employer_________________
Occupation:_________________Date of Birth______________SS #: ___________________

MOTHERS NAME: First Name_________________________Last Name_______________________ Middle Initial________

Address_________________________________City______________________State______Employer_________________
Occupation:_________________Date of Birth______________SS #: ___________________

DENTIST: Name of Dentist___________________________Last seen________________Reason for visit_______________

CONFIRMATIONS: We confirm appointments via email/text messaging therefore; please provide us with the following information:

Best Contact Information:

Mom's Number_____________________________□ Home □ Cell (if cell who is provider?) __________________□ Work

Email address_____________________________@__________________.______________

Dad's Number_____________________________□ Home □ Cell (if cell who is provider?) ___________________□ Work

Email address_____________________________@__________________.______________

Patient's Number_____________________________□ Home □ Cell (if cell who is provider?) _________________□ Work

FINANCIAL RESPONSIBILTY: ____
Address if different from patients____
Home Phone___________________Cell Phone_____________________Email address______________________________
PRIMARY DENTAL INSURANCE - Insurance Company_________________________Insurance phone #__________________
(policy holder's full name) ____Date of Birth___________________________
SS/ID #: _________________________Relationship to patient_______________Group #___________________________
SECONDARY DENTAL INSURANCE - Insurance Company______________________Insurance phone #_________________
(policy holders full name)____Date of Birth ____________________________
SS/ID #: __________________________Relationship to patient______________Group #____________________________

MEDICAL HISTORY

YES	NO	UNK	
□	□	□	Birth defects/hereditary problems
□	□	□	Bone fractures or major injuries
□	□	□	Any injuries to face, head neck
□	□	□	Arthritis or joint problems
□	□	□	Endocrine or thyroid problems
□	□	□	Diabetes or low sugar
□	□	□	Kidney problems
□	□	□	Cancer, tumor
□	□	□	Radiation treatment or chemotherapy
□	□	□	Stomach ulcer, hyperacidity, acid reflux
□	□	□	Immune system problems
□	□	□	History of osteoporosis
□	□	□	Sexually transmitted diseases
□	□	□	AIDS/HIV positive
□	□	□	Hepatitis, jaundice, or other liver problems
□	□	□	Polio, mononucleosis, tuberculosis, pneumonia

YES	NO	UNK	
□	□	□	Seizures, fainting spells, neurologic problems
□	□	□	Mental health disturbance or depression
□	□	□	Vision, hearing or speech problems
□	□	□	History of eating disorder (anorexia, bulimia)
□	□	□	High or low blood pressure
□	□	□	Excessive bleeding or bruising
□	□	□	Chest pain, shortness of breath, tire easily
□	□	□	Heart defects, murmur, rheumatic heart disease
□	□	□	Angina, arteriosclerosis, stroke or heart attack
□	□	□	Skin disorder (other than acne)
□	□	□	Do you eat a well-balanced diet
□	□	□	Frequent headaches or migraines
□	□	□	Frequent ear infections, colds, throat infections
□	□	□	Asthma, sinus problems, hay fever
□	□	□	Tonsil or adenoid condition
□	□	□	Do you frequently breathe through your mouth

Have you had allergies or reactions to any of the following?

YES NO UNK

- □ □ □ Local anesthetics; novocaine/lidocaine/xylocaine
- □ □ □ Latex (gloves or balloons)
- □ □ □ Aspirin
- □ □ □ Metals (Jewelry, clothing snaps)
- □ □ □ Penicillin
- □ □ □ other antibiotics___________________________
- □ □ □ Ibuprofen
- □ □ □ Acrylics
- □ □ □ Plant pollens
- □ □ □ Animals
- □ □ □ Foods
- □ □ □ Other substances__________________________

DENTAL HISTORY

YES NO UNK

- □ □ □ History of speech problems or speech therapy
- □ □ □ Difficulty breathing through nose
- □ □ □ Food impaction between the teeth
- □ □ □ Mouth breathing habit or snoring at night
- □ □ □ Frequent oral habits (sucking finger, thumb)
- □ □ □ Teeth causing irritation to lip, cheek or gums
- □ □ □ Supernumerary or congenitally missing teeth
- □ □ □ Chipped or injured primary or permanent teeth
- □ □ □ Any teeth treated with root canals/pulpotomies
- □ □ □ History of canker sores/cold sores
- □ □ □ Permanent or extra teeth removed
- □ □ □ Abnormal swallowing (tongue thrust)
- □ □ □ Tooth grinding/clenching
- □ □ □ Clicking, locking in jaw joints
- □ □ □ Soreness in jaw muscles or face muscles
- □ □ □ Ringing in ears, difficulty in chewing/opening jaw
- □ □ □ History of TMJ/TMD problems
- □ □ □ Any broken or missing fillings
- □ □ □ Problems with previous dental treatment
- □ □ □ History of gum disease/pyorrhea
- □ □ □ Jaw fractures, cysts, infections
- □ □ □ Any sensitive or sore teeth

Do you think that any of your child's activities affect his/her face, teeth or jaws? How?

____

____

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication________________ Taken for___________________

Medication________________ Taken for___________________

Medication________________Taken for___________________

Does your child take antibiotic pre-medication before dental procedures? □ Yes □ No

Does your child have/had a substance abuse problem?
□ Yes □ No

Does your child chew or smoke tobacco? □ Yes □ No

Have you noticed any changes in your child's face or jaws?

____

Any other physical problems/concerns?

____

How often does your child brush? Floss?

____

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders______Diabetes________Arthritis_______

Severe allergies_________Unusual dental problems________

Jaw size imbalance_______Other medical conditions_______

____

____

GENERAL INFORMATION

What concerns you about your child's teeth?

____

What concerns your child about his/her teeth?

____

How does your child feel about orthodontic treatment?

____

Has your child had previous orthodontic treatment? Please describe.____________________________________

RELEASE AND WAIVER: I authorize release of any information regarding my orthodontic treatment to my dental insurance company.

Signature ____ Date ____________________________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health. I also understand that if I have insurance coverage with the above insurance company, I assign directly to Dr. Shoff all orthodontic benefits. I understand that an appropriate credit bureau report may be obtained. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature ____ **Date** ____________________________________

Health History Reviewed by Dr. Robert C. Shoff, DDS______________________________________ Date ________________________

MEDICAL HISTORY UPDATES OR CHANGES

Date_______________Changes____ Patient initials ____________

Dental Staff Signature____**Date**_______________