This form is fillable. Click in Patient's name to begin.

C|S|O
CRAIG & STREIGHT

(405) 321-1926

**NORMAN OFFICE**
706 24th Avenue NW
Norman, OK 73069

**MUSTANG OFFICE**
1476 N. Mustang Rd.
Mustang, OK 73064

**SOUTH OKC OFFICE**
10001 S Penn Ave Suite 130
Oklahoma City, OK 73159

# CHILD HEALTH HISTORY FORM

**DATE:**

## PATIENT INFORMATION

| PATIENT'S NAME | | PREFERRED NAME | | GENDER |
|---|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP | |
| CELL PHONE | | HOME PHONE | | |
| DATE OF BIRTH | AGE | SCHOOL | GRADE | |

## PARENTS OR GUARDIANS

| FATHER/GUARDIAN NAME | EMPLOYER | CELL PHONE | MOTHER/GUARDIAN NAME | EMPLOYER | CELL PHONE |
|---|---|---|---|---|---|
| | | | | | |

PATIENT LIVES WITH:
O Both Parents Separately O Both Parents Together O Mother O Father O If other, please list

EMAIL ADDRESS

| PATIENT ADDRESS (IF DIFFERENT FROM PARENTS) | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| HOW DID YOU HEAR ABOUT OUR OFFICE? | WHAT IS THE REASON YOU ARE SEEKING AN ORTHODONTIC EVALUATION? |
|---|---|
| | |

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?
O Yes O No Reason:

PLEASE LIST OTHER FAMILY MEMBERS SEEN IN OUR OFFICE & THEIR RELATIONSHIP TO THIS PATIENT

## MEDICAL HEALTH INFORMATION

***DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING CONDITIONS?***

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| DIABETES | ○ | ○ | FAINTING SPELLS, SEIZURES, EPILEPSY | ○ | ○ | ADD / ADHD | ○ | ○ |
| STROKE | ○ | ○ | SCARLET FEVER, RHEUMATIC HEART DISEASE | ○ | ○ | EXCESSIVE BLEEDING OR BRUISING | ○ | ○ |
| ASTHMA | ○ | ○ | LATEX OR NICKEL SENSITIVITY/ALLERGY | ○ | ○ | DEPRESSION / MENTAL ILLNESS | ○ | ○ |
| HEPATITIS A, B OR C | ○ | ○ | HIGH OR LOW BLOOD PRESSURE | ○ | ○ | TONSILS/ADENOIDS REMOVED | ○ | ○ |
| TONSILLITIS | ○ | ○ | AIDS, HIV POSITIVE | ○ | ○ | AUTISM / ASPERGERS | ○ | ○ |
| HEART DEFECT, HEART MURMUR, HEART DISEASES | ○ | ○ | HERPES, FEVER BLISTERS | ○ | ○ | | | |

| IS YOUR CHILD TAKING ANY MEDICATION AT THIS TIME? | ALLERGIES (MEDICINE OR OTHER) |
|---|---|
| ○ Yes ○ No If yes, please list | ○ Yes ○ No If yes, please list |

DOES YOUR CHILD HAVE ANY HEALTH ISSUES NOT LISTED THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

| NAME OF YOUR CHILD'S PHYSICIAN | PHONE | IS PATIENT ADOPTED? | IF FEMALE, HAS SHE BEGUN MENSTRUATING? |
|---|---|---|---|
| | | ○ Yes ○ No | ○ Yes ○ No |

## DENTAL INSURANCE INFORMATION

| PRIMARY INSURANCE COMPANY NAME | ADDRESS |
|---|---|
| | |

| INSURANCE COMPANY PHONE | GROUP/PLAN NUMBER | PRIMARY POLICY HOLDER NAME | |
|---|---|---|---|
| EMPLOYER | SOCIAL SECURITY NUMBER OR ID # | RELATIONSHIP TO PATIENT | DATE OF BIRTH |
| | | | |

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# CHILD HEALTH HISTORY FORM

| SECONDARY INSURANCE COMPANY NAME | | ADDRESS | |
|---|---|---|---|
| INSURANCE COMPANY PHONE | GROUP/PLAN NUMBER | SECONDARY POLICY HOLDER NAME | |
| EMPLOYER | SOCIAL SECURITY NUMBER OR ID # | RELATIONSHIP TO PATIENT | DATE OF BIRTH |

DO YOU PARTICIPATE IN A FLEX PLAN?
○ Yes ○ No

I authorize release of any information relating to this claim and understand I am responsible for all cost of dental treatment.

SIGNATURE

I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

SIGNATURE

## DENTAL HEALTH INFORMATION

| IS YOUR CHILD EXPERIENCING ANY DENTAL PROBLEMS? ○ Yes ○ No | DATE OF LAST DENTAL VISIT | ANY TREATMENT NEEDED? |
|---|---|---|
| HOW OFTEN DOES YOUR CHILD BRUSH AND FLOSS EACH DAY? Brushes ____ times per day Flosses ____ times per day | CHILD'S DENTIST | PHONE |

***DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH ISSUES?***

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| PREVIOUS ORTHODONTIC TREATMENT | ○ | ○ | CHRONIC MOUTH BREATHER | ○ | ○ | HEAD/NECK, JAW OR TOOTH INJURY | ○ | ○ |
| FEAR OF DENTAL TREATMENT | ○ | ○ | TONGUE THRUST | ○ | ○ | CLICKING OR POPPING OF THE JAW JOINTS | ○ | ○ |
| FINGER, THUMB OR LIP SUCKING HABIT | ○ | ○ | SORE OR BLEEDING GUMS | ○ | ○ | CLENCHING OR GRINDING | ○ | ○ |
| MISSING PERMANENT TEETH | ○ | ○ | PERMANENT TOOTH EXTRACTION | ○ | ○ | TOOTH SENSITIVITY TO HEAT, COLD OR SWEETS | ○ | ○ |
| DIFFICULTY CHEWING | ○ | ○ | JAW PAIN (JOINT, EAR, SIDE OF FACE) | ○ | ○ | | | |

## PERSONAL INFORMATION

DOES THE PATIENT HAVE ANY SIBLINGS?
○ Yes ○ No If yes, what are their ages?

| PLEASE LIST ANY SPECIAL INTERESTS OF THE PATIENT (SPORTS, HOBBIES, ETC.). | PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT: ○ Very Motivated ○ Will Cooperate (if needed) ○ Not Motivated |
|---|---|

## AUTHORIZATION TO TREAT A MINOR

I have read and I understand the above questions. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We will discuss your treatment with parents / legal guardians / person(s) financially responsible for your treatment / referring doctor and or dentist / for the furtherment of your treatment.

I understand that if I choose to proceed with recommended treatment, the next step includes additional diagnostic records. I consent to the taking of photographs, models & x-rays for diagnostic purposes.

PARENT/GUARDIAN SIGNATURE | PRINT NAME | DATE

You can submit the file by emailing the file to admin@craigandstreight.com or print it and bring it with you to your initial consultation.

By sending this form via email, I'm aware that information are not encrypted. I understand the risks of unencrypted email.