Cavanaugh & Nondorf Orthodontics

Medical/Dental History Form for Child

Patients Last Name:_____First:_____Date:_____
Date of Birth: _____ Age:_____ Sex:_____ Home Phone:_____ Cell Phone:_____
Patients Address:_____City:_____State:_____Zip:_____
Responsible Parties Email:_____
Patients School:_____Sports, Hobbies & Avocations:_____
Fathers Last Name:_____ First:_____Cell Phone:_____
Address:_____City:_____ State:_____Zip:_____
Occupation:_____Employer:_____ Work Phone:_____
Mothers Last Name:_____ First:_____ Cell Phone:_____
Address:_____City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____ Work Phone:_____
In case we cannot reach you: Person to contact_____ Phone #_____

Medical History

Health Quality: □ Good □ Fair □ Poor Allergies: □ Nickel □ Drug □ Other:_____
Has the patient had any of the following: (Please Circle)

Jaw Noises/Pain	Diabetes	Kidney Problems	Sinus Problems	Immune Disorder	Lip or Tongue Biting
Frequent Headaches	Heart Disease	Bleeding Gums	Arthritis	Speech Impairment	Nail Biting
Snoring	Epilepsy	Liver Disease	Convulsions/Seizures	Tonsils/Adenoids	Asthma
Rheumatic Fever	Excessive Bleeding	Cold Sores/Fever Blisters	Dental Anesthetic Sensitive	Mouth Breathing	Hemophilia
Gag Easily	Thyroid Problems	Dizziness or Fainting	Grinding of Teeth	Thumb/Finger Sucking	Difficult Breathing
Latex Sensitivity	Artificial Joints	AIDS/HIV	Radiation Therapy	Chemotherapy	Sleep Apnea

Other Medical Concerns:_____

Physician:_____ Under Physician's Care at Present? (Y or N)_____
For What:_____
List Drugs Regularly Taken & Reason:_____

Dental History

Name of Patients Dentist:_____Last Dental Visit:_____
Dental Work Being Done Now?_____If Yes What?_____
Has Patient Ever Received a Blow to the Teeth or Jaw?_____If Yes, Explain:_____
Has the Patient had Orthodontic Treatment or Evaluation?_____If Yes, By Whom?_____
Family Members in Treatment? _____
Family Members with history of jaw surgery or underbite? _____
What do you feel are the Orthodontic Problems? □ Alignment of Teeth □ Dental Protrusion □ Facial Features
Other:_____
Who First Noticed the Need for Orthodontic Treatment?_____

How did you hear about us? (Please check all that apply): □ Internet Search (ex//Google):_____ □ Website: _____
□ Insurance plan □ Dentist □ Facebook □ Friend: _____ □ Other: _____

Orthodontic Insurance

Primary	**Secondary**
Insured's Social Security #:_____	Insured's Social Security #:_____
Lifetime Maximum Benefit: _____	Lifetime Maximum Benefit: _____
Insurance Co. Name: _____	Insurance Co. Name:_____
Insurance Co. Address:_____	Insurance Co. Address:_____
Insurance Co. Phone #:_____	Insurance Co. Phone #:_____
Group # (plan or policy #):_____	Group # (plan or Policy #):_____
Insured's Name:_____	Insured's Name:_____
Insured's Relation to Patient:_____	Insured's Relation to Patient:_____
Insured's Date of Birth:_____	Insured's Date of Birth:_____
Insured's Employer:_____	Insured's Employer:_____

I certify that I have answered the above questions to the best of my ability. I will not hold Cavanaugh and Nondorf Orthodontics, P.C. or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

_____ _____

Signature of Patient (Parent or Guardian if Patient is a Minor) ***Date***