REBECCA H. HOHL DDS • MS
ORTHODONTIST

Date:_____

Confidential Youth Patient Health History & Information

Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Nickname_____ Birthdate _____ Age _____ Sex _____

Phone number we should use to confirm appointments _____

Email address and/or text we can use for appointment reminders _____

Who may we thank for referring you to our office?_____

Patient's hobbies/interests?_____

Parent & Responsible Party Information

Father's Name_____
Last First Middle

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Home Phone _____ Cell_____

Email Address_____

Employer _____ Occupation _____

Employer Address _____ Work Phone_____

Mother's Name_____
Last First Middle

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Home Phone _____ Cell_____

Email Address_____

Employer _____ Occupation _____

Employer Address _____ Work Phone_____

If divorce is involved, who is the custodial parent?_____

May patient information be released to the non-custodial parent? Yes_____ No_____

Insurance Information

*Primary Dental Insurance Company & Address*_____

Subscriber's Name_____ Subscriber's Social Security Number_____

Relationship to Patient_____

Subscriber's Address_____

Subscriber's Date of Birth_____ Subscriber's Employer_____

Subscriber's ID_____ Group #_____

*Secondary Dental Insurance Company & Address*_____

Subscriber's Name_____ Subscriber's Social Security Number_____

Relationship to Patient_____

Subscriber's Address_____

Subscriber's Date of Birth_____ Subscriber's Employer_____

Subscriber's ID_____ Group #_____

Dental History

What is your child's main orthodontic problem as you (or they) see it? _____

_____

Is your child sensitive about the appearance of his/her teeth? _____

Is your child sensitive about the appearance of any facial features? (nose, chin, lips, etc.)_____

How does your child feel about wearing braces? _____

Has your child ever had an orthodontic consultation? _____ If yes, when?_____

Has anyone in the family received orthodontic treatment? _____ If yes, who? _____

Name of your general dentist: _____

Frequency of dental checkups: once/year_____ twice/year_____ Date of last dental exam _____

Answer yes or no if applicable now or in the past:

Y N Apprehensive about dental care	Y N Jaw joint sounds	Y N Difficulty chewing or opening jaw
Y N Brush teeth daily	Y N Jaw joint pain	Y N Cysts or mouth infections
Y N Floss teeth daily	Y N Jaw "tires" when eating	Y N Frequent clenching of teeth
Y N Fluoride treatments	Y N Jaw catches when opening	Y N Injury to either jaw
Y N Previous orthodontic therapy	Y N Jaw locks in closed position	Y N Injury involving teeth
Y N Frequent canker sores	Y N Jaw locks in open position	Y N Grinding of teeth
Y N Thumb/finger sucking habit	Y N Jaw pain or ringing in the ears	Y N Had periodontal treatment
Y N Frequently chews gum	Y N Wake up with sore teeth	Y N Speech therapy
Y N Discomfort from teeth or gums	Y N Wake up with sore jaw	Y N Body piercing
Y N Bleeding gums	Y N Snores when sleeping	Y N Gag reflux
Y N Teeth that are shifting	Y N Mouth breathing	Y N Any missing permanent teeth
Y N Any injuries to face, mouth, teeth	Y N Sleeps with mouth open	Y N Oral Surgery

Other_____

If you answered **yes** to any of the above, please explain _____

_____

_____

Medical History

Patient's Physician _____ Approximate date of last physical _____

Are you currently seeing a Physical Therapist or Chiropractor?_____, if yes Name & Address_____

Is the patient in good health? Yes_____ No_____ briefly explain, if no _____

Please list any medications patient is currently taking: _____

_____

_____

List any drug allergies or sensitivities patient may have_____

_____

Answer yes or no if applicable now or in the past:

Y N	Allergies (latex-gloves/balloons)	Y N	Anemia	Y N	Hormone therapy	Y N	Emotional problems
Y N	Allergies (metals-jewelry/clothing)	Y N	HIV/AIDS	Y N	Diabetes	Y N	Psychological counseling
Y N	Allergies (acrylic)	Y N	Radiation treatment	Y N	Hepatitis	Y N	Handicap/disabilties
Y N	Allergies (medication)	Y N	Cancer	Y N	Rheumatic fever	Y N	Requires premedication
Y N	Allergies (food)	Y N	Family history of cancer	Y N	Tuberculosis	Y N	Ever been hospitalized
Y N	Allergies (seasonal)	Y N	Bone disorder/bone loss	Y N	Heart disease	Y N	Tobacco use
Y N	Enlarged tonsils	Y N	Immunodeficiency	Y N	Liver disease	Y N	Bottle-fed
Y N	Tonsils/Adenoids removed	Y N	Endocrine problems	Y N	Kidney disease	Y N	Breastfed
Y N	Frequent sore throats	Y N	Heart murmur	Y N	Lung disease	Y N	Born premature___weeks
Y N	Cleft palate/lip	Y N	Heart attack/stroke	Y N	Pneumonia	Y N	Hemophilia
Y N	Asthma	Y N	Congenital heart defect	Y N	Arthritis	Y N	Are you pregnant (females)
Y N	Facial pain	Y N	Frequent headaches	Y N	Tongue thrust	Y N	Back or neck injuries
Y N	Back, neck or shoulder pain	Y N	Frequent nausea	Y N	Dizziness	Y N	Balance issue
Y N	Scoliosis	Y N	Growth problems	Y N	Ear pressure	Y N	Foot/ankle sprain
Y N	Knee, hip, foot pain	Y N	ADHD	Y N	Autism	Y N	Nervous disorder/anxiety
Y N	Intermittent blurred vision	Y N	Tone/ringing in ears	Y N	Torticollis	Y N	Loss of place when reading
Y N	Hypersensitivity (light, sound, movement)	Y N	Difficulty with compre-hension or mental fog	Y N	Hypertension/high blood pressure	Y N	Frequent or large changes in vision prescription

Right or left handed_____ Other_____

If you answered **yes** to any of the above, please explain:_____

_____

Genetic History

Height _____ Weight _____ School_____ Grade_____

Has the patient's shoe size changed recently? _____ Has your child begun puberty? Yes _____ No_____

If your child is a girl, has menstruation begun? Yes____ No____ If your child is a boy, has their voice changed? Yes____ No___

Is the patient adopted?_____ If yes, is the patient aware of this?_____

Does any genetically related family member have a similar facial/dental appearance?_____ _____

List name(s) and birthdates(s) of siblings_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature (Parent/Guardian) Date