



WELCOME!

CHILD HEALTH HISTORY

ABOUT YOUR CHILD

TODAY'S DATE: _____

Child's Name: _____ Birthdate: _____ Male Female

Home #: _____ School: _____ Grade: _____

Email: _____ Nickname: _____

Home Address: _____

Whom may we thank for referring your child? _____

PARENT Parent's Marital Status: Married Divorced Separated Widowed Remarried Single

Mother's Name: _____

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

Home Address: _____

Email Address: _____

Father's Name: _____

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

Home Address: _____

Email Address: _____

INSURANCE INFORMATION

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's Birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

DENTAL HISTORY

Is your child currently in pain? Yes No

Primary reason for today's visit: _____

Has your child experienced problems with past dental work? Yes No

Does your child brush his/her teeth daily? _____ Floss his/her teeth daily? _____

Previous/Present Dentist: _____ Date of last visit: _____

Why did you leave your dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Does/did your child have any of the following habits?

Lip Sucking/Biting

Clenching/Grinding Teeth

Tongue/Cheek Biting

Mouth Breather

Nail Biting

Thumb/Finger Sucking

Used Pacifier

Speech Problems

Chewing on Objects

Nursing Bottle Habits

Tongue Thrust

Breast Feeding

MEDICAL HISTORY

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Address: _____

Is your child currently under the care of a physician? Yes No Please Explain: _____

Describe your child's current physical health: Good Fair Poor Are immunizations current? Yes No

Please list all drugs that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____

Anything you would like to discuss with the doctor in private? Yes No

Has your child had/experienced any of the following?

Abnormal Bleeding

Convulsions

Hives

Rheumatic Fever

AIDS/HIV+

Diabetes

Hospital Stay/Operations

Scarlet Fever

Allergies

Epilepsy

Kidney Problems

Sickle Cell Anemia

Anemia

Handicaps/Disabilities

Liver Problems

Skin Rash

Asthma

Hearing Impairment

Low Blood Pressure

Tonsillitis

Blood Transfusion

Heart Murmur

Lupus

Tuberculosis (TB)

Cancer

Hemophilia

Measles

Chicken Pox

Hepatitis

Mitral Valve Prolapse

Congenital Heart Defect

High Blood Pressure

Mononucleosis

Please discuss any serious medical problems your child has had/experienced: _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign Dr. Sadowski all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____

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