MEDICAL & DENTAL HISTORY (under age 18)

MINOR

Today's Date

_____

Age

_____

Sex: ❑ M ❑ F

School

_____

Grade

_____

Patient's Hobbies

_____

_____

_____

_____

GENERAL INFORMATION

Nickname_____

Patient Name_____ Birthday_____

Address_____ City_____ State____ Zip_____

Phone_____ E-mail of primary contact person_____

Place a check by the primary contact person.

❑ Mother's Name_____ Address_____

Place of Employment_____ Occupation_____

Home Phone_____ Cell Phone_____ Work Phone_____

❑ Father's Name_____ Address_____

Place of Employment_____ Occupation_____

Home Phone_____ Cell Phone_____ Work Phone_____

❑ Step Mother's Name_____ Address_____

Place of Employment_____ Occupation_____

Home Phone_____ Cell Phone_____ Work Phone_____

❑ Step Father's Name_____ Address_____

Place of Employment_____ Occupation_____

Home Phone_____ Cell Phone_____ Work Phone_____

In case of an emergency who should be notified?_____ Phone_____

Whom may we thank for referring you? _____

Reason for seeking orthodontic treatment_____

Siblings_____

DENTAL HISTORY

Name of Dentist _____ Phone_____

Last check-up/cleaning _____

Y	N		Y	N	
❑	❑	Bleeding, swollen, or tender gums	❑	❑	Previous orthodontic treatment
❑	❑	Chewing/smokeless tobacco	❑	❑	Prolonged thumb/finger sucking
❑	❑	Cigarette, pipe, or cigar smoking	❑	❑	Speech problems
❑	❑	Clench the teeth	❑	❑	Still have adenoids
❑	❑	Clicking, pain, popping in jaw joint	❑	❑	Still have tonsils
❑	❑	Difficulty cleaning the teeth	❑	❑	TMJ problems and/or treatment
❑	❑	Grind the teeth	❑	❑	Tooth extractions
❑	❑	Periodontal treatment	❑	❑	Wisdom tooth problems

Dental problems not listed:_____

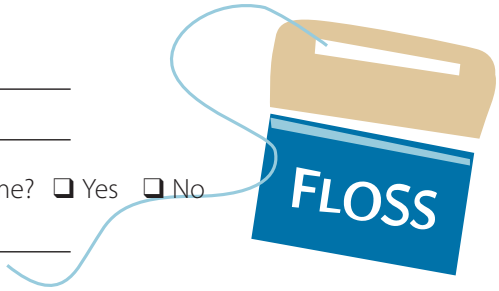
Continued on back....

COOK ORTHODONTICS, P.C.
300 Eagle Crest Dr.
Evansville, IN 47715
(812) 402-3485
www.cook-ortho.com

MEDICAL & DENTAL HISTORY (under age 18)

MINOR

MEDICAL HISTORY



Physician's Name_____

City_____ Date of last visit_____

Is the patient under the care of a physician at the present time? ❑ Yes ❑ No

If so, for what? _____

Describe history of any hospitalizations or operations_____

List any allergies to metal, latex, or medication_____

List any medications the patient is currently taking and why _____

Check "Y" for yes or "N" for no to indicate if the patient has had any of the following:

Y	N		Y	N		Y	N	
❑	❑	AIDS/HIV	❑	❑	Circulatory problems	❑	❑	Kidney disorder
❑	❑	Anemia	❑	❑	Diabetes or Hypoglycemia	❑	❑	Liver disorder
❑	❑	Artificial heart valves	❑	❑	Epilepsy	❑	❑	Lung/Respiratory disorder
❑	❑	Asthma	❑	❑	Eyes, ears, nose, or throat condition	❑	❑	Mitral valve prolapse
❑	❑	Behavioral/ emotional disturbance	❑	❑	Heart murmur	❑	❑	Rheumatic fever
❑	❑	Birth defects/ hereditary disorders	❑	❑	Heart problems	❑	❑	Sexually transmitted disease
❑	❑	Cancer	❑	❑	Hepatitis Type _____	❑	❑	Sinus/Breathing problems
❑	❑	Chemical dependency	❑	❑	High or low blood pressure	❑	❑	Stomach ulcer or Hyperacidity
						❑	❑	Thyroid disorder
						❑	❑	Tuberculosis

Females:

❑ ❑ Is she pregnant? Due Date:_____ Is she nursing? ❑ Yes ❑ No

❑ ❑ Is she anticipating becoming pregnant soon?

❑ ❑ Taking birth control pills?

Has your child had any serious illnesses other than those above? If so, explain._____

INSURANCE INFORMATION

Orthodontic Insurance Coverage: ❑ Yes ❑ No

Primary Insurance Co._____ Subscriber_____

Social Security Number_____ Date of Birth_____

Secondary Insurance Co._____ Subscriber_____

Social Security Number_____ Date of Birth_____

I authorize Cook Orthodontics, P.C. to submit insurance claims on my behalf. My signature also serves as my consent for insurance benefits to be assigned to Cook Orthodontics, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Signature Relation to patient Date

COOK ORTHODONTICS, P.C.
(812) 402-3485
www.cook-ortho.com

I have read and understand the above questions. I will not hold Dr. Cook or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

_____ _____

Signature Relation to patient

_____

Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Cook Orthodontics, P.C. and the dental staff to perform necessary dental/orthodontic services my child may need.

_____

Signature

_____ _____

Print Name Date