FOWLER ORTHODONTICS

Child Health History Information

PATIENT NAME_____
ADDRESS_____CITY_____ZIP_____
HOME PHONE_____CELL PHONE_____
BIRTH DATE_____AGE_____
SCHOOL_____MALE_____FEMALE_____
HOBBIES & INTERESTS_____
EMAIL_____

PARENT INFORMATION

MOTHER_____BIRTH DATE_____
ADDRESS_____
CITY_____ZIP_____
PHONE_____
EMPLOYER_____

FATHER_____BIRTH DATE_____
ADDRESS_____
CITY_____ZIP_____
PHONE_____
EMPLOYER_____

INSURANCE INFORMATION

NAME OF SUBSCRIBER_____SUBSCRIBER ID_____
SOCIAL SECURITY #_____
INSURANCE COMPANY_____
INSURED BIRTH DATE_____

WHO MAY WE THANK FOR REFERRING YOU? _____
DENTIST _____

MEDICAL HISTORY

CHECK ANY THAT APPLY:

DIABETES____	ANEMIA ____	PROLONGED BLEEDING ____
PNEUMONIA ____	EPILEPSY ____	FAINTING/DIZZINESS ____
HEART TROUBLE____	ASTHMA ____	NERVOUS DISORDERS ____
RHEUMATIC FEVER ____	KIDNEY PROBLEMS ____	LIVER PROBLEMS ____
BONE DISORDERS ____	TUBERCULOSIS ____	ENDOCRINE PROBLEMS ____
HEPATITIS ____	GLAUCOMA ____	HIV/AIDS ____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? _____ IF YES WHAT AGE? _____
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN:_____
HISTORY OF ALLERGIES OR DRUG SENSITIVITY:_____
(FEMALES) PREGNANCY YES____ NO _____
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____
HAS THE PATIENT SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____
IS THE PATIENT A MOUTH BREATHER WHILE AWAKE OR ASLEEP? _____
HAVE YOU EVER SEEN AN ORTHODONTIST? _____
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____
DATE OF LAST DENTAL EXAMINATION? _____
WHAT ARE YOUR GOALS FOR YOUR CHILD'S ORTHODONTIC TREATMENT? _____

SIGNATURE_____ DATE _____