

DR. RONALD B. GROSS & DR. JOEL R. FROMER ASSOCIATES

CHILD'S

EXAM DATE: _____

PERSONAL HISTORY

PATIENT NO.: _____

Patient's Name: _____

Prefers to be addressed by: _____

Sex: M F

Age: _____

Birth Date: _____

Address: _____

City: _____

State: _____

Zip Code: _____

School: _____

Grade: _____

Hobbies: _____

Home Ph#: _____

Father's Name: _____

Employer: _____

S.S.#: _____

Father's Address() _____

Occupation: _____

Home Ph.#: _____

Bus.Ph.#: _____

Mother's Name: _____

Employer: _____

S.S.#: _____

Mother's Address() _____

Occupation: _____

Home Ph.#: _____

Bus.Ph.#: _____

Parent's Marital Status:

 Married Single Divorced Separated Widowed

Person Responsible for Account: Father Mother Other(Name): _____

Address: _____

Emergency Contact: _____

Relationship: _____

Ph.#: _____

Has any family member had orthodontic treatment? Y N Name: _____

Has any family member been treated in our office? Y N Name: _____

DENTAL HISTORY

Patient's Dentist: _____

Address: _____

Referred By: _____

Date of Last Exam: _____

X-Rays Taken: _____

Do you now or previously? Suck Thumb /Fingers Bite Lip Snore Mouth Breathe Grind/Clench Teeth

Are you aware of missing or extra permanent teeth? Y N

Do you have any speech problems? Y N

Are there any lumps, sores or irritated areas in mouth? Y N Have you had any injuries to face, mouth, or teeth? Y N

Main Concern _____

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Patient's general health at this time Good Fair Poor

Date of last physical: _____

Is patient under a physician's care or taking any medications at this time? Y N

List Medications: _____

Does patient need to be pre-medicated prior to any dental treatment? Y N

List Meds: _____

Have tonsils and/or adenoids been removed? Y N

Eating Disorders? _____

Patient's Height? _____

Weight? _____

Father's Height? _____

Mother's Height? _____

Any health problems not listed above: _____

CHECK ALL THAT APPLY

Y N HIGH BLOOD PRESSURE
 Y N LOW BLOOD PRESSURE
 Y N HEART MURMUR
 Y N MITRAL VALVE PROLAPSE
 Y N RHEUMATIC FEVER
 Y N FAINTING SPELLS
 Y N TONSILLITIS
 Y N EMOTIONAL PROBLEMS
 Y N HEADACHES

Y N RESPIRATORY PROBLEMS
 Y N TUBERCULOSIS
 Y N ARTHRITIS
 Y N CANCER
 Y N BLOOD DISORDERS/BLEEDING
 Y N HERPES (ORAL COLD SORES)
 Y N EARACHES
 Y N EPILEPSY
 Y N LIVER DISEASE

Y N ALLERGIES: MEDICINE
 Y N LATEX OR METALS
 Y N ALLERGIES: OTHER

 Y N ASTHMA
 Y N DIABETES
 Y N INFECTIOUS DISEASES
 Y N A.D.D.

OTHER: _____

ORTHODONTIC INSURANCE

Primary Insurance Co.: _____ Group #: _____ I.D.# _____

Insured's Name: _____ S.S.# _____ Birth Date: _____

Insured's Employer: _____ Ph.#: _____ Dental Flex/Cafeteria Acct: Y N

Secondary Insurance Co.: _____ Group #: _____ I.D.#: _____

Insured's Name: _____ S.S.# _____ Birth Date: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION. I understand that credit bureau reports may be requested on this account.

Signature of Parent or Guardian

Today's Date: _____
 Update _____ Initial: _____
 Update _____ Initial: _____

OFFICE USE ONLY

PRESENT: M F ALL

RBG JRF

STUDY Y N

INFORMED CONSENT BOOK GIVEN Y N

REC'D Y N

CERAMICS Y N

HIPAA FORM GIVEN Y N

REC'D Y N

INSURANCE Y N

INSURANCE FORM GIVEN Y N

COUPONS EXP. Y N

STUDY _____

CONS _____

PAID _____

RECALL _____ mos.

PENDING _____ mos.

SUSPENSE _____ mos.

FEE RANGE _____ PAYMENT SCHEDULE _____

REFERRAL LETTER _____ Envelope Sent _____

NOTES: _____

C.R. _____