



Office Use Only

Patient # _____
Exam Date: _____ Time: _____

CHILD HISTORY FORM

Date of Birth ____/____/____ Age: Years ____ Months ____

Child Adopted: Yes ____ No ____

PATIENT'S FULL NAME _____
(First) (Middle) (Last)

Nickname _____ Male _____ Female _____ **LATEX ALLERGY: Yes _____ No _____**

Street _____

City _____ State _____ Zip _____

Home Phone _____ School _____ Grade _____

Sports/ Hobbies or Musical Instrument _____

Patient resides with Father Mother Both Other _____

What is your specific reason for today's consultation? _____

Who first noticed the problem? Patient Parent DDS

Names of other family members treated in this office _____

Siblings Yes No Name _____ Age _____ / Name _____ Age _____

Name _____ Age _____ / Name _____ Age _____

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

PARENT'S INFORMATION

Father (Mr., Dr.)

Mother (Mrs., Ms., Dr.)

Name _____

Street Address _____

City/State/Zip _____

Home # _____

Cell# _____

Work # _____

E-mail _____

SS# _____

Employer _____

Marital Status _____

Height _____ ft. _____ in.

_____ ft. _____ in.

Person Responsible for Account: Father _____ Mother _____ Both _____ Other _____ **ORTHODONTIC INSURANCE: Yes _____ No _____**

Person Responsible if Other than Parent:

Name _____ Relationship _____

Street _____

City _____ State _____ Zip _____

Cell # _____ Work # _____ Home # _____

Employer _____



CHILD HISTORY FORM

PATIENT'S NAME _____

DENTAL HISTORY

PATIENT'S DENTIST _____

- Is your child especially apprehensive towards dental visits? Yes No
- Does your child want orthodontic treatment? Yes No
- Has your child ever had a previous orthodontic treatment? Yes No If Yes, when _____
- Has your child ever been treated for a jaw joint problem, including surgery? Yes No
- Has your child ever had any injuries to the face, mouth or teeth? Yes No
- Does your child have any oral habits? Yes No Stopped at Age____ Still Occurring
 - Tongue Thrust Thumb/Finger Sucking
 - Clenching Grinds Teeth
- Is your child a mouth breather? Yes No If yes, All Day Night Only
- Have any other family members had braces or orthodontic treatment? Yes No
- If yes, have any of them been treated by us? _____
- When did your child last see the family dentist? _____

MEDICAL HISTORY

PATIENT'S M.D. _____

- Tonsils Present Yes No Adenoids Present Yes No
- Nickel/Metal Sensitivity Yes No Heart Problems Yes No If Yes, What? _____
- Presently under Physicians Care? Yes No Treatment _____
- Presently under Medication? Yes No Medication List _____
- Drug Allergies** Yes No List _____
- Have you ever had Hepatitis? Yes No If Yes, What Type? _____ Are you in a risk group for Aids? Yes No
- Are there any medical problems not noted that we should be aware of?** No If Yes , what? _____

GROWTH CONSIDERATIONS:

Reached Puberty: Yes No Approx. Date _____ Voice Change: Yes No Approx. Date _____

Notes: _____

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform this practice. I hereby authorize necessary credit information to be obtained by your office. I hereby authorize the taking of x-rays and other records for an initial diagnosis if needed.

Signature (Patient/Responsible Party) _____ Date _____

This information has been reviewed with the above-named individual:

Signature _____ Position _____ Date _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

8311 Bluebonnet Boulevard
Baton Rouge, LA 70810

140 Veterans Boulevard
Denham Springs, LA 70726

Phone: 225-769-1276
Fax: 225-767-3751

www.shermanorthodontics.com

