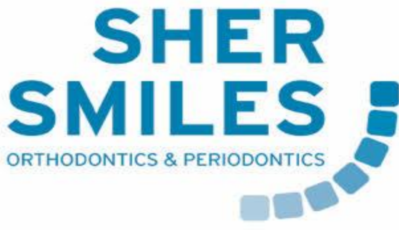



# Confidential Youth Patient Health History and Information

**Date:**___________________

## Confidential Patient Information

Name: ____________________________________________ Gender: M / F Patient's Nickname: __________
Last First Middle

Residence: ____________________________________________________________
Street City State Zip

Birthdate: __________________ School: ______________________________ Grade: __________________

## Confidential Responsible Party Information

Name: ______________________________________________ Gender: M / F Marital Status: ____________
Last First Middle

Residence: ________________________________________________Own: ________Rent: ________
Street City State Zip

Billing Address: ____________________________________________________________
Street City State Zip

How long at this address: _______ Home Phone: _______________________Work Phone: ___________________

Cell Phone: ___________________ Email: ____________________________**Appt. Reminder: Text / Email / Both**

Social Security No: __________________ Birthdate: _______________ Relationship to Patient: ________________

Employer: __________________ Occupation: _______________ Military Pay Grade _____ No Years Employed: ____

Spouse's Name: ____________________________________________________________
Last First Middle

Cell Phone: ___________________ Email: ____________________________**Appt. Reminder: Text / Email / Both**

Social Security No.: __________________ Birthdate: _______________ Work Phone: ____________________

Employer: _________________ Occupation: _________________ Military Pay Grade: _____ No Years Employed: _____

## Insurance Information

Policy Holder's Name: _________________________ D.O.B.: ____________ Social Security No.: ______________

Insurance Company: _____________________ ID No: __________________ Group No.: ___________________

Insurance Company Address: _________________________________ Insurance Co. Phone: ________________

Policy Holder's Employer: ____________________________________________________________

Do you have dual coverage?: Yes / No If yes, Policy Holder's Name / Employer: _________________________________

Insurance Company: _____________________ ID No: __________________ Group No.: ___________________

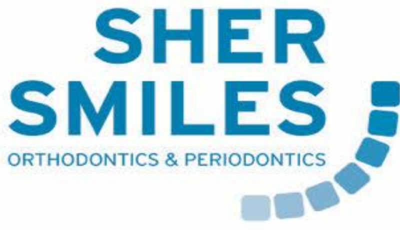
Insurance Company Address: _________________________________ Insurance Co. Phone: ________________

## Emergency Contact Information

Name of Emergency Contact: _________________________________ Relationship: ____________________

Address: ______________________________________________________ Phone: __________________
Street City State Zip

**Whom may we thank for referring you to our office?**________________________________________




# Confidential Youth Patient Health History and Information

## Youth Patient Dental History Information

What is your main orthodontic problem(s)? ________________________________________________

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? ____________________

Are you interested in Traditional Braces? ________________________________________________

Have you had an orthodontic consultation? Yes _____ No _____ If yes, when? ______________________

Has anyone in the family received orthodontic treatment from Sher Smiles? Yes _____ No _____

If yes, who? ________________________________________________

Name of your current general dentist: ______________________________ How many years? _________

Frequency of dental checkups? ____________________ Date of last dental exam: ____________________

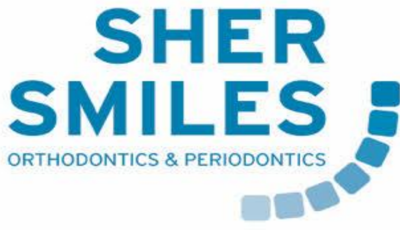
Are there any needed restorations? Yes _____ No _____

Date restorations will be completed? ____________________

## Please check any of the following that apply and explain in the box below:

- ❏ Are you apprehensive about dental care?
- ❏ Have you had any trouble associated with dental treatment?
- ❏ Have you had any teeth extracted?
- ❏ Have you injured or broken any teeth?
- ❏ Do you have any discomfort from teeth?
- ❏ Do you have any missing teeth?
- ❏ Do you have any extra teeth?
- ❏ Do you receive regular fluoride treatment?
- ❏ Do you have discomfort from gums?
- ❏ Are you aware of any swellings or growth in your mouth?
- ❏ Do you suck on your fingers or thumb?
- ❏ Do you have frequent canker sores
- ❏ Have you had any injuries to either jaw?
- ❏ Do you chew on objects such as pens?
- ❏ Do you have regular jaw pain?
- ❏ Do you have limited jaw movement?
- ❏ Do your jaws click or pop?
- ❏ Do you have any trouble eating, chewing or swallowing?
- ❏ Do you habitually grind or clench teeth?
- ❏ Are you in speech therapy currently?
- ❏ Have you had any injuries to you face or mouth?
- ❏ Do you breathe with your mouth open or lips parted?

If you have checked any of the above, please explain:




# Confidential Youth Patient Health History and Information

## Youth Patient Medical History Information

Name & Location of Physician: ______________________________

Are you in good health? __________ Date of last physical: __________

Are you presently under the care of a physician for any illness? ________ Please specify below.

Do you have a history of major illness or been hospitalized? ________ Please specify below

Is there anything you would like to talk to the doctor about in private? ________

## Please check any of the following that apply and explain in the box below:

- ❑ Have you seen a medical specialist?
- ❑ Do you have a tendency to catch colds?
- ❑ Do you have an allergy to latex?
- ❑ Do you have an allergy to metals?
- ❑ Do you have any drug allergies / sensitivities?
- ❑ Do you require pre-medications?
- ❑ Are you taking any drugs or medications?
- ❑ Have you ever received Bisphosphonate treatment or other bone building medications? (e.g. Fosamax, Actinol, Bonival)
- ❑ Do you have gastric reflux?
- ❑ Are you pregnant or breastfeeding?

## Please check any of the following for which the patient has been treated and explain in the box below:

- ❑ AIDS / HIV
- ❑ Asthma
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Bone disorders
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Diabetes
- ❑ Emotional disorder
- ❑ Endocrine problems
- ❑ Fainting or dizziness
- ❑ Frequent headaches or neck aches
- ❑ Heart trouble, defect or murmur
- ❑ Hepatitis
- ❑ Hormone Therapy
- ❑ Jaundice
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Low / High blood pressure
- ❑Multiple Sclerosis
- ❑ Nervous disorder
- ❑ Osteoporosis
- ❑ Prolonged bleeding
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Sleep Apnea / Snoring
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ Thyroid problems
- ❑ Unusual growth patterns

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to Sher Smiles for this patient. Records may be discussed with other health care providers and / or for educational purposes. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party ______________________________ Date” ______________