leap orthodontics

HEALTH HISTORY FORM – MINOR PATIENT

Please completely complete this form so we can provide the safest and most effective treatment. All answers are strictly confidential.

☐ CHAGRIN FALLS ☐ NORTH RIDGEVILLE

PATIENT INFORMATION

Patient's Name: _____ Nickname: _____

Age: _____ Date of Birth: _____ Gender: Choose...

Home Phone: _____ Email Address: _____

Address: _____ City: _____ Zip: _____

School Attending: _____ Family Dentist: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Parent A Name: _____ Relationship to Patient: Choose...

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____ Work Phone: _____

Marital status: ◯ Single ◯ Married ◯ Divorced

Parent B Name: _____ Relationship to Patient: Choose...

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____ Work Phone: _____

Marital status: ◯ Single ◯ Married ◯ Divorced

Please complete if different from child's:

Address: _____ City: _____ Zip: _____

Home Phone: _____

INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ SSN: _____ - _____ - _____

Insurance Company: _____ Phone: _____

SECONDARY INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ SSN: _____ - _____ - _____

Insurance Company: _____ Phone: _____

EMERGENCY INFORMATION

Physician: _____ Physician's Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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MEDICAL HISTORY

Any change in your child's health recently? Yes No Explain: _____

Is your child currently taking any medications? Yes No List: _____

Is your child allergic to any medications? Yes No List: _____

Has your child received a blood transfusion? Yes No Explain: _____

Have your child's tonsils/adenoids been removed? Yes No Explain: _____

Does your child have any of the following conditions?

Heart Murmur	Yes No	Hepatitis	Yes No	Emotional Problems	Yes No
Heart Surgery	Yes No	Diabetes	Yes No	Frequent Headaches	Yes No
Endocrine Disorder	Yes No	Kidney Disease	Yes No	Nervous/Anxious	Yes No
Prolonged Bleeding	Yes No	Liver Disease	Yes No	Cancer	Yes No
Blood Disease	Yes No	Tuberclosis	Yes No	Bone Disorders	Yes No
Hives/Rash	Yes No	Asthma	Yes No	Growth Disorder	Yes No
Fainting	Yes No	Allergies	Yes No	Severe Cystic Acne	Yes No
Frequent Strep Throat	Yes No	Epilepsey	Yes No	Tonsillitis	Yes No
Latex Allergy	Yes No	Asperger's/Autism	Yes No	ADHD	Yes No

Any other conditions we should know about? _____

Because growth can be an important factor in orthodontic treatment, this information aids our selection of treatment alternatives.

Has your son or daughter reached puberty?

Girls – Has she started menstruation? Yes No When? _____
Boys – Has his voice changed? Yes No When? _____

Height: ____**ft**_____**in** Do you feel his/her growth is complete? Yes No

Father's Height: _____ Mother's Height: _____ Adopted? Yes No

Names & Birthdays of brothers and sisters: _____

Siblings/parents had previous orthodontic treatment? Yes No With whom?_____

DENTAL HISTORY

Frequency of dental checkups: Twice a year Once a year Only if a problem exists Never

Date of last visit: _____ Is there any unfinished care? Yes No Explain: _____

Is your child frightened about dental treatment? Yes No Explain: _____

Has your child had an unpleasant experience in a dental office? Yes No Explain: _____

Has your child had face or dental injuries? Yes No Explain: _____

Have any teeth been removed? Yes No Explain: _____

Is there a history if thumb or finger sucking? Yes No Stopped? _____

Have you consulted an orthodontist previously? Yes No With whom: _____

Please indicate if your child has a history of

Clenching teeth
Grinding Teeth
Speech problems
Muscular soreness around head or neck
Headaches (more than occasional)
Which sounds? _____
Jaw joint soreness
Jaw joint clicking
Mouth breathing ___ awake ___ asleep
Jaw joint popping
Ringing in ears

Any other information that would be helpful? _____

Signature: _____ Printed Name: _____ Date: _____

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