Dr. Harold K. Heuszel & Associates, DDS, FAGD
New Patient – Child Forms

Today's Date: _____

About Your Child:

_____ _____ _____ ☐ Male ☐ Female
Last Name First Name MI

Preferred Name: _____ DOB: ____ / ____ / _____ Age: _____

School: _____ Grade: _____

SSN: _____ - _____ - _____ Driver's License #: _____

Sibling: _____ Age: _____

Sibling: _____ Age: _____

Child's Home Address:

_____ _____ _____ _____
Street City State Zip

Who Is With The Child Today? (Name): _____ Relationship: _____

When and where is the best time to reach you? _____

Do you have legal custody of this child? ☐ Yes ☐ No

Child's Parents' Marital Status: ☐ Married ☐ Divorced ☐ Single Parent

Mother's Information:

Name: _____ Phone: _____

Driver's License #: _____ SSN: _____ - _____ - _____

Employer: _____

Father's Information:

Name: _____ Phone: _____

Driver's License #: _____ SSN: _____ - _____ - _____

Employer: _____

Who may we thank for referring you? _____ _____
Name Relationship

Other family members seen by us: _____

Previous/Present Dentist: _____ Address: _____

Previous/Present Dentist Phone: _____ Last Visit: _____

Responsible Party Info:

Name: _____ Employer: _____

SSN: _____ - _____ - _____ Driver's License #: _____

Home Phone: _____ Work/Other Phone: _____

E-Mail Address: _____

Billing Address:

_____ _____ _____ _____
Street City State Zip

Primary Dental Insurance: Orthodontic Coverage: ☐ Yes ☐ No

Insurance Name: _____ Insurance Company Phone #: _____

Insurance Address: _____

Group/Policy #:_____ Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: ____ / ____ / _____

Insured's Employer: _____ SSN: _____ - _____ - _____

Secondary Dental Insurance: Orthodontic Coverage: ☐ Yes ☐ No

Insurance Name: _____ Insurance Company Phone #: _____

Insurance Address: _____

Group/Policy #:_____ Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: ____ / ____ / _____

Insured's Employer: _____ SSN: _____ - _____ - _____

Who is responsible for marking appointments?

Name: _____ Relation: _____

Phone: _____ Ext. _____

E-Mail: _____

Dental History:

Why have you come to the orthodontist today? _____

Is the child currently in pain? ☐Yes ☐No Child's current dental health is: ☐Good ☐Fair ☐Poor

Has the child ever had a serious/difficult problem associated with previous dental work? ☐Yes ☐No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐Yes ☐No

Is the child's water fluoridated? ☐Yes ☐No

Is the child taking fluoridated supplements? ☐Yes ☐No

Does the child brush daily? ☐Yes ☐No Floss daily? ☐Yes ☐No

Type of bristles? ☐Soft ☐Medium ☐Hard

Currently under the care of a physician? ☐Yes ☐No
If yes, please explain: _____

Is the child taking any prescription drugs? ☐Yes ☐No List: _____

Are you allergic to any of the following?:

☐Yes ☐No Aspirin ☐Yes ☐No Erythromycin

☐Yes ☐No Codeine ☐Yes ☐No Dental Anesthetics

☐Yes ☐No Latex ☐Yes ☐No Tetracycline

☐Yes ☐No Penicillin Other: _____

Have you ever had any of the following diseases or medical problems?:

☐Yes ☐No Heart Murm. ☐Yes ☐No Congenital Heart Def.

☐Yes ☐No Cancer ☐Yes ☐No Convulsions/Epilepsy

☐Yes ☐No Diabetes ☐Yes ☐No Abnormal bleeding

☐Yes	☐No	Rheum Fev.	☐Yes	☐No	Hearing impairment
☐Yes	☐No	HIV+/AIDS	☐Yes	☐No	Any Operations
☐Yes	☐No	Hemophilia	☐Yes	☐No	Any Stays In The Hospital
☐Yes	☐No	Asthma	☐Yes	☐No	Kidney/Liver Problems
☐Yes	☐No	Hepatitis	☐Yes	☐No	Handicaps/Disabilities
☐Yes	☐No	Tuberculosis	☐Yes	☐No	Allergies to Any Drugs
☐Yes	☐No	Prosthesis	☐Yes	☐No	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

_____

Does the child have any of the following habits…

☐Yes ☐No Thumb sucking / Finger Sucking

☐Yes ☐No Lip Sucking / Biting

☐Yes ☐No Nail Biting

☐Yes ☐No Nursing Bottle Habits

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that the child may need during treatment.

_____

Signature of parent/guardian Date

The parent/guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.
Initials: _____ Date: _____

Medical History Update:
Date: _____ Sig: _____
Comments: _____

Doctor comments:

_____

_____

_____

_____