CENTRAL PARK ORTHODONTICS
live. laugh. smile.

PATIENT HISTORY - CHILD

Child's Name_____ Male / Female
Last Name First Name Initial Nickname

Address _____

City _____ State _____ Zip _____ Email _____

Home Ph# _____ Cell Ph# _____ Cell Carrier_____

Birthdate _____/_____/_____ Age _____ School Attending _____

Hobbies/Interests _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name_____ Relation to Patient_____

Whom may we thank for referring you? _____

PRIMARY RESPONSIBLE PARTY

Person Responsible for Account _____ Male / Female
Last Name First Name Initial Marital Status

Relation to Patient _____ Birthdate_____/_____/_____ Soc. Sec. #_____

Address (**if different from above**)_____

Cell #_____ Cell Carrier _____ Email_____

Employer_____ Occupation _____

Business Address _____ Business Ph# _____

Insurance Company_____ Phone #_____

Subscriber ID#_____ Group/Policy # _____

SECONDARY RESPONSIBLE PARTY

Person Responsible for Account _____ Male / Female
Last Name First Name Initial Marital Status

Relation to Patient _____ Birthdate_____/_____/_____ Soc. Sec. #_____

Address (**if different from above**)_____

Cell #_____ Cell Carrier _____ Email_____

Employer_____ Occupation _____

Business Address _____ Business Ph# _____

Insurance Company_____ Phone #_____

Subscriber ID#_____ Group/Policy # _____

Please complete both sides

DENTAL HISTORY

Dentist _____ Date of Last Dental Exam _____

Circle (Yes / No) if your child has had problems with any of the following:

Bad Breath	Yes / No	Bleeding gums	Yes / No	Clicking, popping, locking of jaw	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Periodontal treatment	Yes / No	Grinding/clenching teeth	Yes / No
Sores in mouth	Yes / No	Loose/Broken teeth	Yes / No	Thumb/finger sucking	Yes / No
Mouth breathing	Yes / No	Snoring	Yes / No	Nail biting	Yes / No

Any injuries to mouth or chin injury Yes / No If yes please explain _____

Has your child ever been evaluated for orthodontic treatment? Yes / No Orthodontist_____

MEDICAL HISTORY

Physician's Name _____ Phone # _____

Any recent illness(or)surgeries Yes / No If yes describe_____

Is your child currently under physician care Yes / No If yes, describe _____

Do your child still have: Tonsils Yes / No Adenoids Yes / No

For Women: Are you pregnant? Yes / No Taking birth control pills Yes / No

Circle (Y: Yes or N: No) whether your child has (or) had any of the following:

AIDS/HIV+	Y / N	Hepatitis	Y / N	High Blood pressure	Y / N	Stroke	Y / N
Anaphylaxis	Y / N	Diabetes	Y / N	Epilepsy	Y / N	Asthma	Y / N
Fainting	Y / N	Hemophillia	Y / N	Cancer	Y / N	Heart attack	Y / N
Sinus Prob.	Y / N	Heart Murmur	Y / N	Congenital Heart Def.	Y / N	Jaw Pain	Y / N
Headaches	Y / N	Kidney Disease	Y / N	Liver Disease	Y/ N	Tuberculosis	Y / N
Cold Sores	Y / N	Drug/Alcohol abuse	Y / N	Mitral Valve Prolapse	Y / N	Rheum Fever	Y / N

Is your child taking any medication for your bones? Yes / No If yes, List_____
Is your child currently taking any medications? Yes / No If Yes, List_____
Does your child have any drug allergies? If Yes, List all: _____

Allergic to LATEX YES / NO

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 child's medical status. I also authorize the orthodontic staff to perform the necessary orthodontic services my child may need.

I authorize Central Park Orthodontics, on behalf of Dr. George Pliakas, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

I have also read, understand and have been offered a copy of the HIPPA consent form.

_____ _____

Signature **Date**