Tadej ORTHODONTICS
smiles apart

8625 Liberty Park Drive, Suite 101, Bakersfield, CA 93311
661.322.2263 • Fax 661.322.6250
www.tadejorthodontics.com

HEALTH HISTORY

MALE ❑

PATIENT'S NAME_____ BIRTHDATE _____ AGE _____ FEMALE ❑

NAME OF PHYSICIAN _____ LAST VISIT _____

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN? _____ YES ❑ NO ❑

IF YES, FOR WHAT REASON?_____

IS YOUR CHILD CURRENTLY TAKING MEDICATION?_____ YES ❑ NO ❑

IF YES, WHAT? _____

IS CHILD ALLERGIC TO MEDICATIONS? YES ❑ NO ❑

IF YES, WHAT? _____

IS CHILD ALLERGIC TO LATEX, NICKELS (METALS), ETC.? YES ❑ NO ❑ FOOD? YES ❑ NO ❑

IF YES, WHAT? _____

HAS CHILD EVER BEEN HOSPITALIZED?_____ YES ❑ NO ❑

IF YES, WHAT AGE AND FOR WHAT REASON? _____

GENERAL HEALTH? EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑

DOES CHILD HAVE ANY DIFFICULTY BREATHING THROUGH NOSE? _____ YES ❑ NO ❑

DOES CHILD TEND TO BREATHE THROUGH THE MOUTH WHILE SLEEPING? _____ YES ❑ NO ❑

DOES CHILD GRIT OR GRIND TEETH DURING THE DAY OR NIGHT? _____ YES ❑ NO ❑

HAS CHILD EVER HAD ANY BONE, CONNECTIVE TISSUE (COLLAGEN), OR HORMONAL ABNORMALITIES? YES ❑ NO ❑

IF YES, EXPLAIN: _____

DOES CHILD SUCK THEIR THUMB OR FINGERS? _____ YES ❑ NO ❑

HAS CHILD EVER HAD PROBLEMS WITH CLICKING, POPPING OR PAIN IN JAW JOINT? _____ YES ❑ NO ❑

HAS CHILD EVER HAD ANY PREVIOUS ORTHODONTIC TREATMENT? _____ YES ❑ NO ❑

DENTAL HISTORY

NAME OF DENTIST _____ LAST VISIT _____

WHAT SERVICES DID YOU HAVE ON LAST VISIT? _____

DOES CHILD MAKE REGULAR VISITS TO DENTIST? YES ❑ NO ❑ HOW OFTEN? _____

HOW OFTEN DOES CHILD BRUSH? _____USE DENTAL FLOSS? _____

OVER

GROWTH INFORMATION:

AGE OF ONSET OF MENSUS FOR FEMALE PATIENT _____

AGE OF ONSET OF VOICE CHANGE FOR MALE PATIENT _____

HEIGHT _____ WEIGHT _____

HAS YOUR CHILD HAD ANY HISTORY OF THE FOLLOWING:

	YES	NO
HEART TROUBLE OR CONGENITAL HEART LESIONS	❑	❑
RHEUMATIC FEVER	❑	❑
ASTHMA	❑	❑
MALIGNANCIES	❑	❑
HEARING PROBLEMS	❑	❑
DIABETES	❑	❑
NERVOUSNESS OR HYPERACTIVITY	❑	❑
PROLONGED BLEEDING DUE TO A SLIGHT CUT	❑	❑
EMOTIONAL PROBLEMS OR TENSION	❑	❑
SPEECH DISORDER	❑	❑
CEREBRAL PALSY	❑	❑
LUNG PROBLEM	❑	❑
EPILEPSY	❑	❑
HEPATITIS	❑	❑
TAKING APPETITE SUPPRESSANTS	❑	❑

IF YES, WHAT_____

ARE THERE ANY OTHER HEALTH PROBLEMS YOU FEEL MAY AFFECT YOUR CHILD'S TREATMENT?

_____

_____

PARENT'S SIGNATURE_____ DATE _____

QUESTIONS YOU MAY WISH TO ASK AT YOUR CHILD'S CONSULTATION:

_____

_____

_____

_____

_____

_____

_____

UPDATES (DATE & INITIAL) _____ _____ _____ _____

NO CHANGES PARENTS INITIAL_____ _____ _____ _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

A B C

Patients Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____ ❒ Own ❒ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holders Employer _____

Do you have dual coverage? ❒ No ❒ Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate credit bureau reports will be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

It's All About Me!

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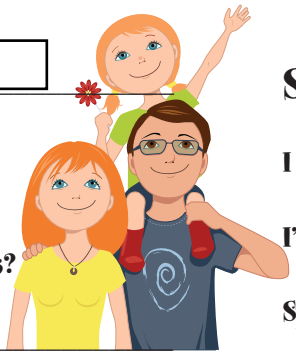
Name

_____

I like to be called



About my family

Has anyone anyone in the family had braces?

I have these pets:

_____

For fun I like to: _____

_____

Favorites:

TV show: _____

Radio station: _____

Song: _____

Color: _____

Number: _____

Food: _____

Animal: _____

Theme park: _____

Board game: _____

Team: _____

Sports figure: _____

Celebrity: _____

Person: _____

School Stuff

I go to school at _____

I'm in ___ grade

Sports I play: _____

_____

❒ Instruments I play: _____

_____

❒ I'm involved in: _____

_____

❒ I like to read: _____

_____

My friends Come here for their braces too:

_____

_____

_____

More fun stuff

What kind of phone do you have?

_____

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