HOSKINSON ORTHODONTICS
FOR CHILDREN & ADULTS

Child Medical History

Today's Date: _____

Patient's Name *last,first*: _____ **DOB:**_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status.

Signature of Parent or
Guardian_____

Primary Care Physician: _____ Date Last
Physical:_____

Is your child currently being treated by a physician? ○ Yes ○ No
Is your child currently taking any prescription or over-the-counter medications? ○Yes ○ NO

List:_____

Has your child had any serious illnesses or operations? If yes, describe:_____
_____

Check if your child has history of the following:

☐Anemia
☐Diabetes/low blood sugar
☐Kidney Disease
☐Thyroid Problem
☐Diabetes/low blood sugar
☐Cancer
☐Radiation/Chemotherapy
☐Hepatitis
☐Heart Defect, murmur,
Rheumatic heart disease
☐Vision,Hearing,Speech Problem

☐ Endocrine/Thyroid Disorder
☐ Asthma,Sinus problem,hayfever
☐ Birth defects,hereditary problem
☐ Skin Rash
☐ Lyme Disease
☐High or low blood pressure
☐Liver Disease
☐Tobacco/Chemical dependency
☐Tuberculosis
☐Mononucleosis
☐Frequent ear infections,colds,throat infections

Allergies: *Check if allergy or reaction to the following*

☐Latex
☐Aspirin,Ibuprofen
☐Acrylics
☐Animals
☐Plant pollens

☐Local anesthetics(novacaine,lidocaine,xylocaine)
☐Metals (jewelry,clothing,snaps)
☐Antibiotics-Penicillin or other
☐Foods_____
☐Other_____

207 Mohawk Ave. Scotia NY 12302
518.372.3424
info@hoskinsonortho.com

HOSKINSON ORTHODONTICS
FOR CHILDREN & ADULTS

Dental History:

General Dentist:_____ Last Visit:_____

What are the main concerns you would like orthodontics to accomplish?
Concerns: _____

Has your child had previous orthodontic treatment ?○Yes ○No
When:_____ Reason:_____

Check if have history:

☐Erupting teeth very early or late
☐ Primary(baby) teeth removed because
○ loose or ○ decayed
☐Sensitive or sore teeth
☐Jaw fracture,cysts, or infection
☐Teeth causing irritation to lip,cheek,gum
☐Jaw joint clicking, popping
☐Treatment for TMJ or TMD
☐Mouth breathing
☐Nail biting
☐Lip sucking/biting
☐Problems associated w/ previous dental treatment
☐Permanent or extra teeth removed
☐Tonsil or adenoid condition
☐Chipped or injured primary or permanent teeth
☐Lost or broken fillings
☐Teeth treated w/ root canal or pulpotomy
☐Teeth grinding or clenching
☐Soreness in jaw or face muscles
☐Diseased gums
☐Thumb/finger sucking
☐Chewing/eating problem
☐Injury to head/neck

Patient's Name:_____

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DOB:_____
Address:_____
City_____ ***State***_____ ***Zip***_____

School_____Grade_____Interests_____
Chief Complaint_____
How Did You Find Us? *Check all that apply:*
☐ Dentist Referral _____
☐ Friend/Family Referral_____
☐ Facebook ☐ Internet Search ☐ Other_____

Prior Orthodontics_____

Father's Name_____

Social Security #_____ DOB_____

Address_____

Email_____

Phone H_____W_____ C_____

Mother's Name_____

Social Security #_____DOB_____

Address (or, same as above ☐)_____

Email_____

Phone H_____ W_____ C_____
Parent's Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

If patient does not live with both parents, with whom does patient live?
☐ Father ☐ Mother ☐ other, _____

_____
Person Responsible for this account: ☐ Father ☐ Mother ☐ Other_____

Address (if different than mother/father):_____

Orthodontic Insurance

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HOSKINSON ORTHODONTICS
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Patient's Name*: first,*_____ *last,*_____

Date of Birth*:*_____

Primary Insurance

Insured's Name_____

Date of Birth_____ Social Security #_____

Employer_____

Insurance Company_____

Address_____

Group # _____ ID #_____

Phone #_____

Insured's Signature (to be kept on file)_____

Secondary Insurance

Insured's Name_____

Date of Birth_____Social Security #_____

Employer_____

Insurance Company_____

Group #_____ ID #_____

Phone #_____

Insured's Signature (to be kept on file)_____

Deleted: ¶

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