Redd Orthodontics
Dr. Thomas B. Redd, DDS, MS

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303-791-6646
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CHILD HISTORY

Today's Date: _____

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below and bring it with you to your appointment.

Child's Name: _____
Goes By: _____ ❒Male ❒Female
Child's Home Address:
_____
Child's Birthdate: _____ Child's Age: _____ Email:_____
Home #: _____ Cell #_____
School:_____ Grade:_____
Who is accompanying your child today?
Name:_____
Do you have legal custody of this child? __❒Yes __❒No
Whom may we thank for referring you to our office? _____
List brothers / sisters with age: _____
General Dentist: _____
Last Visit Date: _____
Parent's Marital Status: _ Single _ Married __ Divorced _Widowed __Separated
Mother's Information: _ Stepmother __Guardian Name: _____
SS #: _____ Birthdate: _____ Home #:_____
Employer: _____Wk #: _____ Ext: _____
How long at current job: _____ Job Title: _____
Father's Information: _ _ Stepfather _ _ Guardian Name: _____
SS #: _____ Birthdate: _____ Home #_____
Employer: _____ Wk #: _____ Ext: _____
How long at current job: _____ Job Title: _____
Person Responsible for the Account: _____
SS #:_____ (if different from above)
Billing Address:_____
Previous Address: _____
Relation: _____ Wk #: _____ Ext: _____ Home #: _____

ORTHODONTIC INSURANCE

Name & Address of Insurance Company: _____

Phone #: _____

Insurance Address: _____

Subscriber ID #: _____ Group #_____

Subscriber Name: _____ SS #: _____ DOB:_____

Employer Name: _____

Employer Phone #: _____

Employer Address: _____

Medical History

What are the main concerns that you would like the orthodontics to accomplish?

_____

_____

Has your child ever been evaluated for or had orthodontic treatment before? ___ Yes ___ No
Have there been any injuries to the face, mouth, teeth, or chin? ___ Yes ___ No
Have adenoids or tonsils been removed? __ Yes __ No
Does your child need pre-medication prior to dental visits? __ Yes __ No
Has puberty begun? __Yes __No Has menstruation begun? (girls) __Yes __No
Does your child brush his/her teeth daily? __Yes __No Floss teeth daily? __Yes __No
Has your child been informed of any missing or extra permanent teeth? __Yes __No
List any musical instruments played _____

Has your child ever had any of the following medical problems? (Please check all that apply)

_____Allergies to latex/metals	_____ Asthma	_____Hemophilia
_____Allergic to any Drugs	_____ Congenital Heart Defect	_____Lupus
_____Cancer	_____ Epilepsy/ Convulsions	_____Hearing Impairment
_____Heart Murmur	_____ Hepatitis	_____Any operations
_____Kidney / Liver Problems	_____ Rheumatic / Scarlet Fever	_____Tuberculosis (TB)
_____Any Hospital Stays	_____Artificial bones/joints/valves	_____Allergic to plastic
_____Diabetes	_____HIV+/ Aids	

Please discuss any medical problems that your child has had:

_____

_____

_____Clenching / Grinding Teeth	_____ Nail Biter
_____Lip Sucking / Biting	_____ Thumb / Finger Sucking
_____Mouth Breather	_____ Tongue Thrust
_____Speech Problems	_____ Nursing/Bottle Habits

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is your child currently under the care of a physician? ❒Yes ❒No
Please describe your child's current physical health: ❒Good ❒Fair ❒Poor

Please list all drugs your child is currently taking:

_____

Please list all drugs your child is allergic to:

_____

This office reserves the right to verify the credit status of potential patients and/or parents or patients prior to extending credit for treatment fees.
I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the orthodontic staff to perform any necessary orthodontic services that my child may need during diagnosis and treatment with my informed consent.
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature:_____ Date:_____