SHERMAN & BALHOFF
SPECIALISTS IN ORTHODONTICS

CHILD HEALTH HISTORY

PATIENT INFORMATION

FIRST NAME	LAST NAME	
BIRTH DATE	SEX ☐ M ☐ F	ADOPTED ☐ Y ☐ N
ADDRESS	CITY	STATE ZIP
SCHOOL	GRADE	HOBBIES

FATHER	MOTHER
FULL NAME (MR, DR)	FULL NAME (MS,MRS,DR)
BIRTH DATE	BIRTH DATE
ADDRESS	ADDRESS
CELL NUMBER	CELL NUMBER
EMAIL	EMAIL
EMPLOYER	EMPLOYER
MARITAL STATUS	MARITAL STATUS

LEGAL GUARDIAN – IF OTHER THAN PARENT

FULL NAME (MR,MS,MRS,DR)	BIRTH DATE
RELATION TO PATIENT	MARITAL STATUS
CELL NUMBER	EMAIL ADDRESS

DENTAL HISTORY

PATIENT'S DENTIST	HOW DID YOU HEAR ABOUT US?
PAST ORTHODONTIC TREATMENT ☐ Y ☐ N	ORTHODONTIST
DOES THE PATIENT HAVE AN ORAL HABITS?	☐ FINGER/THUMB SUCKING ☐ TONGUE THRUST ☐ CLENCHING ☐ GRINDING ☐ OTHER
HAS THE PATIENT EXPERIENCED ANY JAW PAIN/TMJ? (PAST OR PRESENT)	☐ Y ☐ N
HAS THE PATIENT EXPERIENCED ANY DENTAL TRAUMA?	☐ Y ☐ N

MEDICAL HISTORY

PATIENT'S MEDICAL PHYSICIAN	
PRESENTLY UNDER PHYSICIAN'S CARE ☐ Y ☐ N	TREATMENT
CURRENT MEDICATIONS	
ALLERGIES & DRUG REACTIONS	
ADENOIDS PRESENT ☐ Y ☐ N	TONSILS PRESENT ☐ Y ☐ N
DOES THE PATIENT EXPERIENCE ANY OF THE FOLLOWING? ☐ MOUTH BREATHING ☐ SNORING ☐ SLEEP APNEA	
ARE THERE ANY **OTHER MEDICAL CONDITIONS** THAT WE SHOULD BE AWARE OF?	
PUBERTY REACHED ☐ Y ☐ N Approximate Date :	VOICE CHANGE ☐ Y ☐ N

I, THE UNDERSIGNED, HAVE GIVEN THE AFFOREMENTIONED DENTAL AND MEDICAL INFORMATION, HAVE REVIEWED IT AND FIND IT ACCURATE. IF THERE ARE ANY LATER CHANGES TO THE HISTORY RECORD, I WILL SO INFORM THE PRACTICE. I HEREBY AUTHORIZE THE TAKING OF X-RAYS AND OTHER RECORDS FOR AN INITIAL DIAGNOSIS IF NEEDED.

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SIGNATURE (RESPONSIBLE PARTY)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:
CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULPTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
OBTAIN PAYMENT FOR THIRD-PARTY PAYERS.
CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERITIFICATIONS.
I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.
I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPTIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I HAVE READ THE FOREGOING IN ITS ENTIRETY & UNDERSTAND ITS TERMS.
PATIENT NAME

GUARDIAN NAME (IF PATIENT IS A MINOR)	RELATION
PATIENT/GUARDIAN SIGNATURE	

PATIENT'S PRIMARY DENTAL INSURANCE POLICHOLDER

POLICYHOLDER'S NAME		BIRTH DATE
INSURANCE COMPANY	POLICY ID	GROUP NUMBER
RELATION TO PATIENT	SS# __ __ __ - __ __ - __ __ __ __	CELL NUMBER

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY INSURANCE.	**INITIAL**
I UNDERSTAND THAT I MUST UPDATE ANY NEW POLICY INFORMATION & I WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.	**INITIAL**
I AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO SHERMAN AND BALHOFF, APDC.	
SIGNATURE	