HOLBERT family orthodontics

Richmond, VA 23238
804-270-7824

New Kent, VA 23124
804-966-3030

CHILD HEALTH HISTORY FORM

Patient Information

First Name:__________________ Middle Initial:__________ Last Name:_________________________

Nickname:___________________ Birthdate:______________ Gender: Female Male

School:______________________ Grade:_____

Mother's Name:______________________________ Father's Name:___________________________________

Address:___________________________________ City:____

State:_________ Zip:______________ Email (for Appointments):_________________________________

Child lives with:____________________________ Person Financially Responsible:______________________

Person Financially Responsible:_______________________________ Relationship:________________________

Home Phone:___________________ Mom Cell:_____________________ Dad Cell:______________________

Which is the best number for contact:_______________ Whom can we thank for referring you?________________

Names and Birthdates of Siblings:____

Hobbies:____

Insurance Information

Dental Insurance Company:__________________________ Policy Number:_____________________________

Policy Holder's Name:__________________ SSN:_______________________ Birthdate:______________

Policy Holder's Employer:________________________ Work Number:_______________________________

Secondary Dental Insurance:__________________________ Policy Number:_____________________________

Policy Holder's Name:__________________ SSN:_______________________ Birthdate:______________

Policy Holder's Employer:________________________ Work Number:_______________________________

Dental History

Dentist Name:__________________________________ Date of Last Exam:_________________________

Does the patient currently have any untreated/unfinished dental needs?____________________________________

Has the patient had an orthodontic consult or treatment?__________ If so, when?_________________________

What is the patient's main orthodontic concern?

Please circle YES or NO for the following Questions and explain as necessary

Speech problems/therapy?	YES	NO	Grind or clench teeth?	YES	NO
Oral habits (thumb/finger Sucking, lip/nail biting?	YES	NO	Injury to face, jaw teeth or mouth?	YES	NO
Pain, tenderness or noise In jaw?	YES	NO	Unbalance Jaw Size/ Growth	YES	NO
Apprehensive about dental care?	YES	NO	Brush teeth twice daily	YES	NO
Floss teeth daily?	YES	NO	Mouth breathing?	YES	NO
Snores during sleep?	YES	NO	Requires premedication?	YES	NO
Any missing or extra Permanent teeth?	YES	NO	Family history with Orthodontics	YES	NO

If any of the above dental questions were answered YES, please explain:

Medical History

Physician Name:________________________________ Date of Last Exam?___________________________

Address:_______________________________ City:_________________________ Zip:_____________

List any medication currently being taken by the patient:

List any drug allergies or sensitivities that the patient may have:

Please circle YES or NO for the following questions and explain as necessary

Rheumatic fever:	YES	NO	Tuberculosis/lung disease	YES	NO
Pneumonia	YES	NO	Liver disease	YES	NO
Kidney disease	YES	NO	Heart attack/stroke	YES	NO
Heart disease	YES	NO	Congenital heart defect	YES	NO
Heart murmur	YES	NO	Hemophilia	YES	NO
Hypertension/high blood pressure	YES	NO	Prolonged bleeding/transfusion	YES	NO
Anemia	YES	NO	HIV/AIDS	YES	NO
Hepatitis	YES	NO	Tonsils/Adenoids removed	YES	NO
Cancer	YES	NO	Received radiation treatment	YES	NO
Growth problems	YES	NO	Endocrine problems	YES	NO
Hormone therapy	YES	NO	If Female, pregnant or nursing	YES	NO
Latex/metal allergy	YES	NO	Nervous disorders	YES	NO
Bone disorders/bone loss	YES	NO	Diabetes	YES	NO
Seizures/epilepsy	YES	NO	Handicaps/disabilities	YES	NO
Asthma	YES	NO	Arthritis	YES	NO
Treated for emotional problems	YES	NO	Osteoporosis or low bone density	YES	NO
Autism	YES	NO	ADHD/ADD	YES	NO

Please explain any YES responses from above:

Patients Under 18

Has patient begun puberty?____________________

If female, has menstruation begun?____________________ If so, when?_______________________

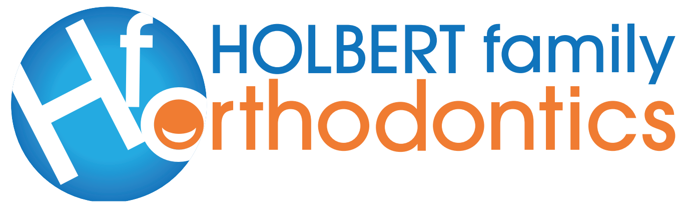
If male, has voice changed or facial hair appeared:____

Has the patient grown significantly in the last year?____

Patient's interest in orthodontic treatment:____

Signature:____ Date:______________________

Relationship to patient:____________________________



AAOIC SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

First Name ______ M.I. ______ Last Name ______

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

* Although exposure is unlikely, do you accept the risk and consent to treatment? Yes ❑ No ❑

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's orthodontic appointment.

Patient/Parent's Signature ______ Date ______