CHILD HISTORY FORM for Dr. Jay Galati DDS, MSD, PC

Date________________________

Child's full name____
Male_____ Female _____ Date of Birth ______________ Age _________________
Child's home address____Zip________
School child attends _______________________________ Grade ________________
Special interests/Hobbies ____

Who may we thank for referring you to our office? ___________________________
Who is the patient's General Dentist? _______________________________________

Who is financially Responsible for the account?
Mother____, Father____, Both____, Other__________________________________

Mother's Name _________________________________Date of Birth_____________
_____Married _____Divorced _____Widow _____ Single _____Remarried
_____ Step-mom ______ Guardian
Address____ Zip______________
Home phone ___________________ Cell phone _______________________________
Employer______________________ Address _________________________________
Occupation________________________________ Work phone __________________
Drivers License #:________________ State:____ SSN:________________________

Father's Name ___________________________________Date of Birth____________
_____ Married ______ Divorced _____Widow ______Single _____Remarried
______Step-Dad _____ Guardian
Address____ Zip______________
Home phone ____________________ Cell phone _______________________________
Employer ________________________ Address _________________________________
Occupation_________________________________ Work phone __________________
Drivers License #:________________ State:____ SSN:_________________________

ORTHODONTIC INSURANCE INFORMATION

Primary insurance information: Insured's Name _______________________________
Social security number_____________________ Date of Birth_____________________
Insurance Company_________________________ Phone Number __________________
Place of Employment____
Address____________________________________City_______State______Zip_______
Group number ________________________ID Number __________________________

WE WILL NEED A COPY OF DENTAL PLAN INSURANCE CARD

DENTAL AND MEDICAL HISTORY

Patients Name: ____

Please circle yes or no and give any details:

Yes No Are you taking any medications now? Please list: _____________________

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Yes No Are you allergic to any medications?________________________________

Yes No Do you have a history of a major illness? ______________________________

Yes No Have you ever had speech therapy? If yes how long? ____________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ____________

Yes No Do you have TMJ? ______________ Any joint noise?___________________

Yes No Any Pre-med required before seeing patient in dental chair?_______________

Please circle the appropriate answer for medical conditions below:

Yes No AIDS
Yes No Allergies
Yes No Anemia
Yes No Artificial Joints
Yes No Asthma
Yes No Arthritis
Yes No Behavioral Disorder
Yes No Blood Clots
Yes No Blood Disease
Yes No Cancer or Tumor
Yes No Dizziness/Fainting
Yes No Diabetes
Yes No Epilepsy
Yes No Excessive Bleeding
Yes No Hay Fever

Yes No Heart Murmur
Yes No Hepatitis
Yes No High Blood Pressure
Yes No Mental Disorder
Yes No Nervous Disorder
Yes No Radiation Treatment
Yes No Respiratory Problems
Yes No Rheumatism
Yes No Stroke
Yes No Tuberculosis
Yes No Thyroid Disease
Yes No Allergy to Codeine/Penicillin
Yes No Any trauma to face, jaw or teeth
Explain ____________________________

Benefits of orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

By signing below, I am stating that I have read and fully understand the above. I also recognize that my diagnostic records and my name may be used for educational and promotional purposes. I truthfully answered all of the above questions to the best of my knowledge and agree to inform this office of any changes in my medical, dental, or family history. In addition, I hereby authorize Dr. Jay R. Galati to perform a complete orthodontic evaluation.

____ ____________________
Signature of patient, parent or guardian Date