

MORRONE KAYE MEDICAL/DENTAL HISTORY - CHILD

Patient Name: _____ Date of Birth: _____ Age: _____ Grade: _____

Please check if you have had any of the following:

- | | | |
|---------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Allergy to Medications | <input type="checkbox"/> Tonsils/Adenoids Removed | <input type="checkbox"/> Facial Injuries - Mouth, Chin |
| <input type="checkbox"/> Digestion Problems - GERD | <input type="checkbox"/> Allergy to Plastic/Latex | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Heart Murmur Pre-Med/No Pre-Med | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Strep Infections |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Disabilities | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney/Liver Disorders | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Orthopedic Implant | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> HIV |

Please explain any checked answers: _____

Is there any other significant medical history you feel we should know? _____

Please list any medications currently taken: _____

Is antibiotic premedication needed for dental visits? (Please circle one) YES NO
Has puberty begun? Males - Voice Change YES/NO Females - Menstruation YES Date: _____
NO

Physician's Name _____
Dentist's Name _____ **Last Dental Visit** _____

Please check if you currently have any of the following oral habits:

- | | | |
|---------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Thumb/Finger Sucking | <input type="checkbox"/> Other - Please List |
| <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Tongue Thrusting | _____ |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Mouth Breathing | _____ |
| <input type="checkbox"/> Gum Chewing | <input type="checkbox"/> Lip/Cheek Biting | _____ |

Musical Instruments Played : _____ **Hobbies :** _____

Please list any significant dental or medical history that may affect your child's treatment (ie missing teeth, jaw alignment problems, growth disturbances, etc.): _____

Please list all sibling's legal names and birthdates: _____

Whom may we thank for referring you to our office? _____

Please state your reason for this consultation: _____

Have you previously seen an orthodontist? YES NO **If so, who?** _____

Was any treatment performed? YES NO **If yes, please explain** _____

Have any oral x-rays recently been taken by your dentist or a specialist? YES NO

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The above information is true to my knowledge. I, as custodial parent/guardian of the above minor child, give my consent for examination of this patient by the doctors and staff of Morrone & Kaye Orthodontics, P.A.

Signature _____ Print Name _____ Date _____

MORRONE KAYE MEDICAL/DENTAL HISTORY - CHILD

PARENT/GUARDIAN INFORMATION

Name : _____ () Mom () Dad () Stepmom () Stepdad () Other
Current Address : _____ E-Mail Address _____
Length at Address : _____ Phone : (W) _____ (H) _____ (C) _____
SS# _____ Marital Status : () Single () Married () Divorced () Widowed
Occupation : _____ Employer : _____
Employer's Address : _____ Years with this Employer _____

Spouse Name : _____ () Mom () Dad () Stepmom () Stepdad () Other
Current Address : _____ E-Mail Address _____
Length at Address : _____ Phone : (W) _____ (H) _____ (C) _____
SS# _____ Marital Status : () Single () Married () Divorced () Widowed
Occupation : _____ Employer : _____
Employer's Address : _____ Years with this Employer _____

OTHER RESPONSIBLE PARTY (if different from above)

Name : _____ () Mom () Dad () Stepmom () Stepdad () Other
Current Address : _____ E-Mail Address _____
Length at Address : _____ Phone : (W) _____ (H) _____ (C) _____
SS# _____ Marital Status : () Single () Married () Divorced () Widowed
Occupation : _____ Employer : _____
Employer's Address : _____ Years with this Employer _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance :

Subscriber's Name : _____
Date of Birth : _____ SS# _____
Insurance Company : _____
Insurance Company Address : _____
Insurance Company Phone # _____ Insurance ID # _____
Group # _____ Local # _____
Do you have orthodontic coverage under this plan ? YES NO
Do you have dual coverage ? YES NO If yes, please complete secondary information below.

Secondary Dental Insurance :

Subscriber's Name : _____
Date of Birth : _____ SS# _____
Insurance Company : _____
Insurance Company Address : _____
Insurance Company Phone # _____ Insurance ID # _____
Group # _____ Local # _____
Do you have orthodontic coverage under this plan ? YES NO