



CROWDER
ORTHODONTICS

WELCOME!

CHILD HEALTH HISTORY

ABOUT YOUR CHILD

TODAY'S DATE: _____

Child's Name: _____ Preferred Name: _____

Birthday: _____ Age: _____ Male Female

Home Address: _____

Home #: _____ School: _____ Grade: _____

Hobbies/sports/special interests: _____

How did you hear about our office? _____

Names and ages of other children: _____

PARENT

Mother's Name: _____

DOB: _____ SS#: _____

Home Address _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Employer: _____ Occupation: _____

Father's Name: _____

DOB: _____ SS#: _____

Home Address _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY

Person Responsible for Account: _____

Billing Address: _____

Home #: _____ Cell #: _____ Work #: _____

Relationship: _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's Birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's Birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

DENTAL HISTORY

Primary reason for today's visit? _____

Injuries to face, mouth or teeth? _____

Has your child experienced problems with past dental work? Yes No

Any missing/extra teeth? _____

Previous/Present Dentist: _____ Date of last visit: _____

Any difficulty with swallowing or chewing _____

Does/did your child have any of the following habits?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Tongue/Cheek Biting | <input type="checkbox"/> Mouth Breather |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Thumb/Finger Sucking | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Chewing on Objects |
| <input type="checkbox"/> Tongue Thrust | | | |

MEDICAL HISTORY

Is patient adopted? _____ at what Age? _____.

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Address: _____

Is your child currently under the care of a physician? Yes No Please Explain: _____

Describe your child's current physical health: Good Fair Poor Are immunizations current: Yes No

Please list all drugs that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____

Adolescent females: Has menstruation begun? Yes No

Has your child experienced any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems/Murmur | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> (HIV+) Immune Def. | <input type="checkbox"/> Tonsils/Aderoids removed |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospital Stay/Operations | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Kidney/Liver Problems | <input type="checkbox"/> Other not listed |
| <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Latex Allergy | |

Please discuss any serious medical problems your child has had/experienced: _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign Dr. Crowder all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____

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