Youth Health History Form
Date:____/_____/_____

Charles C. Low DDS, MS, INC.
ORTHODONTICS
2258 Foothill Blvd, Suite 800 La Cañada, CA 91011
818-236-3636 • www.GotBeautifulSmile.com

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ Date of Birth____/_____/_____ Age _____ M / F (Circle)
Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Names and ages of other siblings in family _____

Patient's Dentist _____ Date of last dental exam ____/_____/_____ recent x-rays? Y / N (Circle)

Has patient been placed on an oral hygiene program by a general dentist? ☐No ☐Yes - How often are your visits?_____

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Parents are: ☐Married ☐Divorced ☐Separated ☐Other _____

Name _____ Relationship to Patient:_____
Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Employer _____ Work Phone _____ Occupation _____

Name #2 _____ Relationship to Patient: _____
Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Employer _____ Work Phone _____ Occupation _____

INSURANCE INFORMATION

Primary Policy Holder's Name_____ SS # or Policy #_____
Last First

Insurance Company _____ Group #_____ Date of Birth of Insured____/_____/_____

Ins. Co. Address_____ Ins. Co. Phone _____

Secondary Policy Holder's Name_____ SS # or Policy #_____
Last First

Insurance Company _____ Group #_____ Date of Birth of Insured____/_____/_____

Ins. Co. Address_____ Ins. Co. Phone _____

I hereby authorize and direct payment of the dental benefits to Dr. Charles C. Low based on the dictates of my plan. The signature below will represent the signature on file for any insurance billing.

Signature _____ Date: ____/_____/_____

DENTAL HISTORY

Reason for Orthodontic Examination_____

Has patient had previous orthodontic treatment/consultation? ☐No ☐Yes explain _____

Has either parent or other children had orthodontic treatment? ☐No ☐Yes explain _____

Check any of the following that apply to patient:

☐ Speech Problems	☐ Thumb Sucking	☐ Have Tonsils Removed	☐ Lip Biting
☐ Nail/Finger Biting	☐ Bleeding Gums	☐ Grinding Teeth	☐ Food Collection Between Teeth
☐ Periodontal Treatment	☐ Mouth Breather	☐ Missing Teeth	☐ Clicking/Popping of Jaw
☐ Extra Teeth	☐ Trauma to Teeth/Jaw	☐ Vomit/Gags easily	☐ Apprehension in dental office

Please explain if any of the above was checked:_____

Any other dental related issues not listed above (explain) _____

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MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Patient's Height _____ Patient's Weight _____ Date of last medical exam _____/_____/_____

Is patient under care of a physician now? ☐No ☐Yes - explain _____

Has patient been hospitalized? ☐No ☐Yes - explain _____

Has patient ever had surgery? ☐No ☐Yes - explain _____

Has patient reached puberty? ☐Yes ☐No Girl - started menstruation? ☐Yes ☐No Boy - has voice changed? ☐Yes ☐No

Does patient have a tendency for? (check all that apply): ☐Colds ☐Sore Throats ☐Ear Infections

Has patient had any history or difficulty with any of the following? Please circle a response to each.

A.I.D.S./H.I.V.	Yes No	Cerebral Palsy	Yes No	Hay Fever	Yes No	Pneumonia	Yes No
Anemia	Yes No	Cleft Lip/Palate	Yes No	Hearing Problems	Yes No	Premature Birth	Yes No
Abnormal Bleeding	Yes No	Convulsion	Yes No	Heart Problems	Yes No	Psychiatric Treatment	Yes No
Bisphosphanate Meds	Yes No	Developmental Disability	Yes No	Hepatitis	Yes No	Rheumatic Fever	Yes No
Blood Transfusion	Yes No	Diabetes	Yes No	Jaundice	Yes No	Sinus Problems	Yes No
Bone Disorder	Yes No	Endocrine Problems	Yes No	Kidney Disease	Yes No	Thyroid Disease	Yes No
Bruise/Bleed Easily	Yes No	Epilepsy	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Cancer	Yes No	Fainting or Dizziness	Yes No	Nervous Disorders	Yes No		

Other (please explain) _____

If any of the above was circled "Yes", please explain dates of occurrence and any additional information: _____

_____

Any broken bones? ☐No ☐Yes If yes, please list _____ Healed satisfactorily? ☐Yes ☐No

Has patient ever had an asthmatic attack? ☐No ☐Yes If yes, Mild Moderate Severe When and how often? _____

Is patient on any medication(s)? ☐No ☐Yes List names and purpose: _____

_____

Is patient allergic to, or ever had an adverse reacton to the following? If yes - Please circle ALL that apply:

Aspirin	Barbiturates	Sedatives	Penicillin	Local anesthetics	Amoxicillin	Sleeping pills
Sulfa drugs	Cosmetic Jewelry	Latex	Nickel	None Known	Others: _____	

Musical instrument(s) played with mouth or lips _____ Sport(s) played with mouth guard _____

I understand that the information that I have given is correct, that it will be held in confidence and 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 dental service my child may need.

Signature of parent / guardian _____ Date _____

**********FOR OFFICE USE ONLY**********

Dental and Medical History reviewed by _____ (initial of Doctor)

Additional Notes: _____

_____

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