VIVA SMILES™

BRANDON HOANG, DMD
Orthodontist - Specialist in Orthodontics & Dentofacial Orthopedics
9639 Chapman Avenue, Garden Grove, CA 92841
Office: 714-530-VIVA | Fax: 714-530-8483
office@vivasmilesdental.com | www.vivasmilesdental.com

Child Medical History Form

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

TELL US ABOUT YOUR CHILD

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First Mi.

Birthdate ____/____/____ Age: _____ ☐ Male ☐ Female

Email Address: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home # _____ SS # _____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

GENERAL INFORMATION

Who is accompanying the child today? _____

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____ Last Visit Date: _____

Dentist's Phone: _____

Relative or Friend not living with you: _____

Name: _____ Phone # _____

Address: _____

_____
City State Zip

PARENT'S INFORMATION

Who is responsible for account? _____ Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthday: ____/____/____

Address: (If different than Child's) Home # _____

_____
Apt/Condo #

_____
City State Zip

SS # _____ DL # _____

Work # _____ Ext _____ Cell # _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____
Apt/Condo #

_____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
Apt/Condo #

_____
City State Zip

Insurance Phone # _____ Insured's ID # _____

Group # (Plan, Local, or Policy #) _____

☐ **Mother** ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthday: ____/____/____

Address: (If different than Child's) Home # _____

_____
Apt/Condo #

_____
City State Zip

SS # _____ DL # _____

Work # _____ Ext _____ Cell # _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____
Apt/Condo #

_____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
Apt/Condo #

_____
City State Zip

Insurance Phone # _____ Insured's ID # _____

Group # (Plan, Local, or Policy #) _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature Date

CONTINUE ON BACK

DENTAL & MEDICAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Does your child require antibiotics before dental treatment? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? ☐ Yes ☐ No

Please select your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

Y N Latex Y N Nickel/Metals Y N Plastic

Has your child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	ADD/ADHD	Y	N	Hearing Impairment
Y	N	AIDS/HIV+	Y	N	Heart Murmur
Y	N	Any Hospital Stays/Operations	Y	N	Hemophilia
Y	N	Artificial Bones/Joints/Valves	Y	N	Hepatitis
Y	N	Asperger Syndrome	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Problems
Y	N	Autism	Y	N	Mitral Valve Prolapse
Y	N	Cancer	Y	N	Prosthetics
Y	N	Congenital Heart Defect	Y	N	Rheumatic Fever
Y	N	Convulsions	Y	N	Scarlet Fever
Y	N	Diabetes	Y	N	Sickle Cell Disease/Traits
Y	N	Epilepsy	Y	N	Tuberculosis (TB)

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Are your child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems your child has had:

_____

_____

Does/did your child experience any of the following?

Y	N	Breast Feeding	Y	N	Nursing Bottle Habits
Y	N	Clenching/Grinding Teeth	Y	N	Speech Problems
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

List any musical instruments played:

_____

_____

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

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest confidence 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 dental/orthodontic services my child may need.

Signature of Parent or Guardian _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Signature of Dentist _____ Date _____

Doctor's Comments: _____

_____

_____

_____

MEDICAL HISTORY UPDATE

Has there been any change in child's health status since your last visit? Y N

If Yes, please explain. _____

_____

Has there been any change in your child's health status since your last visit? Y N

If Yes, please explain. _____

_____

_____
Patient Signature Date

_____
Dentist Signature Date

_____
Patient Signature Date

_____
Dentist Signature Date