

CHILD HEALTH & BUSINESS QUESTIONNAIRE

(Confidential information necessary for your files and your health)

Today's Date _____

Patient's Name (last) _____ (first) _____ DOB _____ Age _____

Address _____ City _____ Postal Code _____

Mother's Name _____ Home # _____ Work # _____ Cell# _____

Address _____ City _____ Postal Code _____

(if different from Patient)

No. # of Years _____ if less than two; Previous Address _____

Occupation _____ Employer _____ E-Mail _____

Father's Name _____ Home# _____ Work# _____ Cell# _____

Address _____ City _____ Postal Code _____

(if different from Patient)

No.# of Years _____ if less than two; Previous Address _____

Occupation _____ Employer _____ E-Mail _____

Siblings' Names and Ages _____

Dentist _____ Physician _____

-
1. Is your child adopted?..... YES NO
 2. Has your child reached puberty?..... YES NO
Girls: menstruation started?..... YES NO
Boys: voice changed?..... YES NO
 4. Have you noticed a rapid rate of growth in the past year?..... YES NO
 5. Is your child in good health?..... YES NO
 6. Is your child currently under the ongoing care of a physician for a specific condition?..... YES NO
If Yes, explain: _____
 7. Has your child ever been hospitalized or had a serious illness or accident?..... YES NO
If Yes, explain: _____
 8. Is your child presently taking any medicine?..... YES NO
 9. Please circle any illness your child has ever had:
Anemia Tuberculosis Inflammatory Rheumatism
Allergies Epilepsy Kidney or Liver disease
Asthma Glaucoma Rheumatic Fever
Diabetes Fainting Spells High or low blood pressure
Heart Trouble Other _____

OVER

10. Please circle any of these drugs your child has ever taken:

Penicillin	Blood thinners	Digitalis
Cortisone	Tranquilizers	Thyroid
Nitroglycerin	Dilantin	Aspirin
Ibuprofen	Other _____	_____

11. Please circle any of these items that your child has had a bad reaction to:

Local Anesthetics	Codeine	Insulin	Barbituates	LATEX
Aspirin	Penicillin	Iodine	Metals: _____	Other _____

12. Does your child suffer frequent colds?..... YES NO
13. Does your child have difficulty breathing through the nose?..... YES NO
14. Has your child had abnormal bleeding associated with previous extractions, surgery or trauma?..... YES NO
15. Has your child ever had an injury to their head, neck, face or chin? YES NO
16. Is there any other information I should know about your child's health or previous dental treatment? YES NO

If Yes, explain: _____

17. Does your child have a metal or latex sensitivity?..... YES NO

18. What is the main reason for seeking orthodontic care for your child? _____

PARENTAL CONSENT FOR A MINOR

I AUTHORIZE ALL NECESSARY DENTAL SERVICES AND METHODS BE RENDERED FOR _____
(Patient's Name)

Date: _____ Signature: _____ Relationship: _____
(Parent or Guardian)

INSURANCE INFORMATION

Subscriber	_____	(2) _____
Insurance Company	_____	_____
Group/Policy	_____	_____
I.D./Cert.No	_____	_____
Subscriber's DOB.	_____	_____

Financing with Dr. Leigh Harfield Professional Corporation is available on approved credit. I understand and consent to such pre-approval when and if payment plans are arranged.

Date: _____ Signature: _____
(Parent or Guardian)