Child Health History

PATIENT INFORMATION

NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

D.O.B.: AGE: MALE/FEMALE ☐ ☐

PARTY RESPONSIBLE FOR ACCT.:

PARENT'S MARITAL STATUS:

REFERRED TO THIS OFFICE BY:

WHAT IS YOUR REASON FOR SEEKING AN ORTHODONTIC EVALUATION?

SPECIAL MEDICAL ALERT - *For office use only*

PARENT OR GUARDIAN INFORMATION

FATHER'S NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

MOTHER'S NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

FATHER'S OCCUPATION:

BUS. ADDRESS:

BUS. PHONE: BUS. FAX: BUS. E-MAIL:

CELL PHONE:

MOTHER'S OCCUPATION:

BUS. ADDRESS:

BUS. PHONE: BUS. FAX: BUS. E-MAIL:

CELL PHONE:

PERSONAL INFORMATION

1. Does your child have any special hobbies or interests? ❒ Yes ❒ No
   Please describe: _____
2. Does your child have brothers and sisters? (list age and sex) _____
3. Has your child been diagnosed as having a learning disability or behavioral disorder? ❒ Yes ❒ No
   Please describe: _____

MEDICAL

PATIENT'S PHYSICIAN NAME: _____

ADDRESS: _____ **PHONE:** _____

Is the patient:

1. Under physicians care? ❒ Yes ❒ No
2. Taking medication? ❒ Yes ❒ No

Does the patient have a history of:

3. Abnormal delivery? ❒ Yes ❒ No
4. Hospitalizations? ❒ Yes ❒ No
5. Rheumatic Fever, Heart Disease, or Heart Murmur? ❒ Yes ❒ No
6. Respiratory problems? ❒ Yes ❒ No
7. Mouth breathing? ❒ Yes ❒ No
8. Prolonged bleeding? ❒ Yes ❒ No
9. Diabetes? ❒ Yes ❒ No
10. Thyroid or Hormone Therapy? ❒ Yes ❒ No
11. Severe headaches? ❒ Yes ❒ No
12. Pains of face or head? ❒ Yes ❒ No
13. Anemia? ❒ Yes ❒ No
14. Epilepsy? ❒ Yes ❒ No
15. Allergies (i.e., aspirin, penicillin, Novocain, etc.)? ❒ Yes ❒ No

    _____

16. Are there any special medical conditions of which we should be aware? ❒ Yes ❒ No

    Please describe: _____

    _____

DENTAL

PATIENT'S DENTIST'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Does the patient:

1. Have a fear of dentists? ❒ Yes ❒ No
2. Receive speech therapy? ❒ Yes ❒ No

Does the patient have a history of:

3. "Cold sores" or acutely sore mouth? ❒ Yes ❒ No
4. Thumb or finger habits? ❒ Yes ❒ No
5. Soreness of jaw muscle or jaw joint? ❒ Yes ❒ No
6. Previous orthodontic therapy? ❒ Yes ❒ No

GENETIC

1. Is the patient adopted? ❒ Yes ❒ No
   If yes, is the patient aware of it? ❒ Yes ❒ No
2. Has any family member had orthodontic treatment? ❒ Yes ❒ No

MATURATIONAL

Ht: _____ Wt: _____

1. *(If Female)* Has the patient started to menstruate? (Age:) ❒ Yes ❒ No
2. *(If Male)* Has his voice changed? ❒ Yes ❒ No
3. *(If Male)* Has facial hair appeared? ❒ Yes ❒ No

I give permission to release any pertinent information to any involved insurance companies or medical/dental professionals.
To the best of my knowledge, the above statements are true and accurate. I agree to inform this office of any changes in the status of my child's health.

Signature: _____ *Date:* _____

Matthew J. Busch, D.D.S.,
PRACTICE LIMITED TO ORTHDONTICS
AND DENTOFACIAL ORTHOPEDICS

1701 East Woodfield Road, Suite 500
Schaumburg, Illinois 60173

847-517-1333

Visit us at www.BORNTOSMILE.com

"Form & Function Through Art, Science & ***Teamwork***"

Matthew J. Busch, D.D.S., Ltd.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Matthew J. Busch, D.D.S., Ltd. I hereby authorize, as indicated by my signature below, Matthew J. Busch, D.D.S., Ltd. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purposes.

_____ _____
Print Name Address

_____ _____
Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4. _____ Date Added / Removed: _____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

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Through
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Special Authorization

for patient privacy protection

Matthew J. Busch, D.D.S., Ltd.

I, _____, consent to allow Matthew J. Busch, D.D.S., Ltd.
to use **my / my son's / my daughter's** (check one):

- ☑ dental / medical photos
- ☑ radiographs
- ☑ study models
- ☑ TMJ score
- ☑ and other information (please describe): _____

from **my**/ **my son's / my daughter's** dental record for (check one):

- ☑ In-office Born to Smile board / In-office Digital Display Board
- ☑ website marketing/social media
- ☑ scientific papers
- ☑ lectures
- ☑ demonstrations and other educational events
- ☑ other (please describe): _____

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice delivered to Matthew J. Busch, D.D.S., Ltd. within 30 days of signature.

Matthew J. Busch, D.D.S., Ltd.
Name of Practice

_____
Patient Date

By: _____
Authorized Staff Member Date

_____
Print Patient Name

_____
Guardian / Parent Date

Please Note: Dr. Busch is on the faculty of the University of Pennsylvania School of Dental Medicine and may use treatment plans with before & after photographs in his presentations to the orthodontic residents for teaching purposes.