moon ORTHODONTICS

(913)-782-7223
(913)-780-1886
smile@moonortho.com
www.moonortho.com
601 N. Mur-Len, Suite 3, Olathe, KS 66062 / 14247 Metcalf Ave, Overland Park, KS 66223

ABOUT YOUR CHILD

FIRST NAME:	MIDDLE NAME:	LAST NAME:	
PREFERRED NAME/NICKNAME:	AGE:	DATE OF BIRTH:	GENDER: M F
ADDRESS:	CITY:	STATE:	ZIP:
CELL #:	SCHOOL:		GRADE:

DOES THE PATIENT HAVE ANY SIBLINGS? ◯ YES ◯ NO If yes, what are their ages?

PLEASE LIST ANY SPECIAL INTERESTS OF THE PATIENT (SPORTS, HOBBIES ETC):

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT: ◯ Very Motiviated ◯ Will Cooperate (if needed) ◯ Not motivated

PARENTS OR GUARDIANS

PATIENT LIVES WITH: ◯ BOTH PARENTS SEPARATELY ◯ BOTH PARENTS TOGETHER ◯ MOTHER ◯ FATHER ◯ OTHER

FATHER/GUARDIAN:	EMPLOYER:	DAY-TIME PHONE:	CELL PHONE:
MOTHER/GUARDIAN:	EMPLOYER:	DAY-TIME PHONE:	CELL PHONE:

PARENT ADDRESS: if different from patient's

CITY:	STATE:	ZIP:

HOW DID YOU HEAR OF MOON ORTHODONTICS?

WHAT IS THE REASON YOU ARE SEEKING AN ORTHODONTIC EVALUATION?

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ◯ YES ◯ NO REASON:

WHERE?	WHEN?

PLEASE LIST OTHER FAMILY MEMBERS SEEN IN OUR OFFICE AND THEIR RELATIONSHIP TO PATIENT:

DENTAL INSURANCE INFORMATION

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ PARTNERED ◯ WIDOWED ◯ DIVORCED ◯ SEPARATED

PRIMARY INSURANCE COMPANY NAME:		SECONDARY POLICY HOLDER NAME:	
ADDRESS:		ADDRESS:	
GROUP ID:	MEMBER ID:	GROUP ID:	MEMBER ID:
PRIMARY POLICY HOLDER NAME:		SECONDARY POLICY HOLDER NAME:	
SSN: _____/_____/_____	DATE OF BIRTH: __/__/___	SSN: _____/_____/_____	DATE OF BIRTH: __/__/___
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	
DO YOU PARTICIPATE IN A FLEX PLAN? ◯ YES ◯ NO		DO YOU PARTICIPATE IN A FLEX PLAN? ◯ YES ◯ NO	

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MEDICAL HEALTH INFORMATION

IS PATIENT ADOPTED? ◯ YES At What age? ____ ◯ NO

NAME OF YOUR CHILD'S PHYSICIAN:

ADDRESS:

PHONE:

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

ADD/ADHD ◯ YES ◯ NO	Fainting Spells, Seizures ◯ YES ◯ NO	Joint Replacement or Implant ◯ YES ◯ NO
AIDS, HIV POSITIVE ◯ YES ◯ NO	Heart Defect, Heart Murmur, Heart Disease ◯ YES ◯ NO	Scarlet Fever, Rheumatic Heart Disease ◯ YES ◯ NO
Asthma ◯ YES ◯ NO	Hepatitis ◯ YES ◯ NO	Tonsillitis ◯ YES ◯ NO
Excessive Bleeding / Bruising ◯ YES ◯ NO	Herpes/Fever Blisters ◯ YES ◯ NO	Tonsils or Adenoids Removed ◯ YES ◯ NO
Cancer ◯ YES ◯ NO	High or Low Blood Pressure ◯ YES ◯ NO	Tuberculosis ◯ YES ◯ NO
Diabetes ◯ YES ◯ NO		

DOES THIS PATIENT NOW OR HAS HE/SHE EVER TAKEN BISPHOSPHONATES, INCLUDING FOSAMAX, DIDRONEL, BONIVA, AREIDA, ACONTEL, SKELID, OR ZOMETA? IF SO, WHICH DRUG?

IF FEMALE, HAS SHE BEGUN MENSTRUATION? ◯ YES ◯ NO

DOES YOUR CHILD HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

IS THE PATIENT ALLERGIC TO LATEX, NICKEL, OR METALS?

OTHER SENSITIVITIES/ALLERGIES:

IS YOUR CHILD TAKING ANY MEDICATION AT THIS TIME? ◯ YES ◯ NO If yes, please list:

DENTAL HEALTH INFORMATION

IS YOUR CHILD EXPERIENCING ANY DENTAL PROBLEMS? ◯ YES ◯ NO

DATE OF LAST DENTAL VISIT: ____/____/____

HOW OFTEN DOES YOUR CHILD BRUSH AND FLOSS EACH DAY? Brushes ____ times per day. Flosses ____ times per day

CHILD'S DENTIST:

ADDRESS:

PHONE:

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Difficulty Chewing ◯ YES ◯ NO	Jaw Pain (Joint, Ear, Side Of Face) ◯ YES ◯ NO	Permanent Tooth Extraction ◯ YES ◯ NO
Clenching or Grinding ◯ YES ◯ NO	Tongue Thrust ◯ YES ◯ NO	Tooth Sensitivity To Heat, Cold, Or Sweets ◯ YES ◯ NO
Finger or Lip Sucking Habit ◯ YES ◯ NO	Head/neck, Jaw Or Tooth Injury ◯ YES ◯ NO	Previous Orthodontic Treatment ◯ YES ◯ NO
Chronic Mouth Breather ◯ YES ◯ NO	Missing Or Extra Permanent Teeth ◯ YES ◯ NO	Clicking Or Popping Of The Jaw Joints ◯ YES ◯ NO
Soda/Juice Over Consumption ◯ YES ◯ NO	Sore Or Bleeding Gums ◯ YES ◯ NO	Fear Of Dental Work ◯ YES ◯ NO

I have read and understand the above questions. I will not hold Dr. Moon or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE