CRANFORD ORTHODONTICS
Alexander D. Cranford DMD, MS
91 JEFFERSON PARKWAY, SUITE B
NEWNAN GA 30263
OFFICE (770) 251-4444

Child Patient Health History Form

All sections must be complete prior to submitting.

Patient Information

Date

Age

Last Name

First Name

Middle Name

Preferred Name

Address

City

State

Zip

Birth Date

Gender

Preferred Phone #

Phone Type? ○ Other ○ Mobile ○ Home

Whom may we thank for recommending our services

Names and Ages of Children in Family

☐ Not Applicable

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Responsible Party Information

Last Name

First Name

Middle Name

Preferred Name

Address

City | State | Zip

Select your option

Home Phone | Cell Phone | Work Phone

Marital Status | Birth Date | Relationship to Patient

Employer | Occupation | Number of Years Employed

Responsible Party Email for Appointment Reminders, etc

Responsible Party Information (Secondary)

Party to be included in patient's chart for scheduling and appointment matters.

☐ Not Applicable

Parent's Name | Preferred Name

Relationship to Patient | Employer | Occupation

Birth Date | Work Phone | Cell Phone

Who is the financially responsible party for the account?

Emergency Information

Name of nearest relative (not living with you)

Phone Number(s) | Relationship to Patient

Dental Insurance

Primary Insurance *(if insured's address is different than responsible party, please inform our office)*

☐ Not Applicable

Do you have Insurance coverage for dentistry?

- ○ Yes
- ○ No
- ○ Unsure

Do you have Insurance coverage for orthodontic treatment?

- ○ Yes
- ○ No
- ○ Unsure

Insured's Full Name

Insured's Birth Date

Member ID or Social Security #

Relationship to Patient

Insurance Company

Phone # for Provider Services

Group #

Insured's Employer

Secondary Insurance ***(if insured's address is different than responsible party, please inform our office)***

☐ Not Applicable

Do you have Insurance coverage for dentistry?

- ○ Yes
- ○ No
- ○ Unsure

Do you have Insurance coverage for orthodontic treatment?

- ○ Yes
- ○ No
- ○ Unsure

Insured's Full Name

Insured's Birth Date

Member ID or Social Security #

Relationship to Patient

Insurance Company

Phone # for Provider Services

Group #

Insured's Employer

Fee Expectations

If treatment is recommended for your child, what is your ideal DOWN payment?

- ○ $350 - $499
- ○ $500 - $749
- ○ $750 +
- ○ I would like to pay in full and receive a courtesy discount
- ○ I have an HSA or FSA I would like to use

If treatment is recommended for your child, what is your ideal MONTHLY payment?

- ○ $100 - $199
- ○ $200 - $299
- ○ $300 - $399
- ○ I have an HSA or FSA I would like to use

If treatment is recommended for your child, what is your desired time frame to begin this exciting journey?

- ○ I would like to get started today
- ○ I would like to get on the schedule
- ○ I am shopping around for other opinions
- ○ I am unsure

Health Questionnaire

Patient's Physician

Address

Physician's phone number

Date of most recent physical exam

General Information

What concerns you about your child's teeth and jaws?

Other family members with similar condition?

Who suggested that your child might need orthodontic treatment?

Has your child ever had any previous orthodontic treatment or consultation?

Why did you select our office?

List interests and hobbies

What school does the patient attend?

Grade?

NOW OR IN THE PAST HAS THE PATIENT HAD:

Diabetes	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Endocrine or Thyroid	○ Yes ○ No
Asthma	○ Yes ○ No	Anemia	○ Yes ○ No	Prolonged Bleeding	○ Yes ○ No
Cancer	○ Yes ○ No	Epilepsy/Seizure	○ Yes ○ No	Hay Fever	○ Yes ○ No
Gastrointestinal Disorders	○ Yes ○ No	Herpes	○ Yes ○ No	Handicap/Disability	○ Yes ○ No
Radiation/Chemotherapy	○ Yes ○ No	Sickle Cell	○ Yes ○ No	Hearing Impairment	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Stroke	○ Yes ○ No	Sinus Problems	○ Yes ○ No
Ulcers	○ Yes ○ No	Drug Problems	○ Yes ○ No	Liver Involvement	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Fainting or Dizziness	○ Yes ○ No
Bone Disorders	○ Yes ○ No	Hepatitis	○ Yes ○ No	Nervous Disorders	○ Yes ○ No
Sleep Apnea	○ Yes ○ No	Heart Defect, Murmur	○ Yes ○ No	Kidney Involvement	○ Yes ○ No
Birth/Hereditary Problems	○ Yes ○ No	Immune System Problems	○ Yes ○ No	History of Eating Disorders	○ Yes ○ No
Arthritis or Joint Problems	○ Yes ○ No	Depression/Mental Health	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Heart disease, Heart attack	○ Yes ○ No	Skin Disorder	○ Yes ○ No

Is the patient in good health?

Does the patient smoke or chew tobacco?

Does the patient take antibiotic pre-medication prior to dental visits?

Has the patient ever taken medications to strengthen their bones?

List any drugs, medications, nutritional supplements now being taken and give reasons

Any medical, dental, or surgical problems not covered above?

Allergies

Does the patient have allergies to the following

Latex
- ○ Yes
- ○ No

Erythromycin
- ○ Yes
- ○ No

Penicillin
- ○ Yes
- ○ No

Codeine
- ○ Yes
- ○ No

Nickel or other metals
- ○ Yes
- ○ No

Tetracycline
- ○ Yes
- ○ No

Dental Anesthetics
- ○ Yes
- ○ No

Aspirin
- ○ Yes
- ○ No

Acrylics
- ○ Yes
- ○ No

Other allergies not listed

Airway and Sleep Questionnaire

☐ Not Applicable

While sleeping, does your child...

have trouble breathing or struggle to breath?
- ○ Yes
- ○ No
- ○ Don't Know

stop breathing during the night?
- ○ Yes
- ○ No
- ○ Don't Know

have "heavy" or loud breathing?
- ○ Yes
- ○ No
- ○ Don't Know

snore regularly?
- ○ Yes
- ○ No
- ○ Don't Know

Upon awakening, does your child...

have a problem with sleepiness during the day?
- ○ Yes
- ○ No
- ○ Don't Know

Additionally...

does your child have tired eyes/dark circles under the eyes?
- ○ Yes
- ○ No
- ○ Don't Know

does your child have seasonal allergies?
- ○ Yes
- ○ No
- ○ Don't Know

does your child have trouble breathing through the nose?

- ○ Yes
- ○ No
- ○ Don't Know

has your child been diagnosed with ADD, ADHD or another learning disability?

- ○ Yes
- ○ No
- ○ Don't Know

Dental History

Patient's Dentist

Reason for Last Visit

How often does the patient have dental check-ups?

Teeth Grinding or Clenching?

Past/Present Injuries To the face, mouth, or teeth?

Missing or extra permanent teeth?

Clicking or discomfort in jaw joints near ears?

treated for "TMJ" or "TMD"?

To the best of my knowledge, the health information is complete and correct. I will not hold Cranford Orthodontics responsible for any errors or omissions that I have made in completing this form. I will notify Cranford Orthodontics of any changes in my medical or dental health. I understand that where appropriate, credit bureau reports may be obtained. I have also received a copy and read the notice of privacy practices.

Date

Signature of Patient or Parent if Patient is a Minor

Thank you for completing the above information. Please only click the “Submit” button once, as it may take a few moments to process. Once successfully submitted, you will be redirected back to the previous page and a confirmation message will appear.