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VANCE MISURACA
ORTHODONTICS
Specializing in Orthodontics for Children & Adults

10720 N Oak Hills Pkwy ○
Baton Rouge
Louisiana 70810
225 766 3300 P
225 766 3387 F

17497 Old Jefferson Hwy ○
Prairieville
Louisiana 70769
225 673 3774 P
225 677 9483 F

238 Veterans Blvd ○
Denham Springs
Louisiana 70726
225 665 3434 P
225 665 6565 F

Child Health History

Today's date ________________

Confidential Patient information

Name: ______________________ (last) ______________________ (first) ______________________ (middle) Email: ______________

Address: ______________________ (street) ______________ (city) ______ (state) ______ (zip) Cell: ______________

Home phone: ______________ Birthdate: ______________ Social security #: ______________

If patient is a minor, give parent's or guardian's name: ______________ School: ______________

Whom may we thank for referring your child to our office? ______________

Confidential Responsible Party Information

Name: ______________________ (last) ______________________ (first) ______________________ (middle) Marital status: ______________

Residence: ______________________ (street) ______________ (city) ______ (state) ______ (zip) Email: ______________

Mailing address: ______________________ (street) ______________ (city) ______ (state) ______ (zip) Cell: ______________

How long at this address: ______________ Home phone: ______________ Work phone: ______________

Previous address (if less than 3yrs.) ______________ (street) ______________ (city) ______ (state) ______ (zip) How long at this address: ______________

Social security #: ______________ Birthdate: ______________ Relationship to patient: ______________

Employer: ______________ Occupation: ______________ No. of years employed: ______________

Spouse's name: ______________________ (last) ______________________ (first) ______________________ (middle) Relationship to patient: ______________

Employer: ______________ Occupation: ______________ No. of years employed: ______________

Social security #: ______________ Birthdate: ______________ Work phone: ______________

Insurance information

Policy holder's name: ______________ DOB: ______________ Social security #: ______________

Insurance company: ______________ Group #: ______________ Union local #: ______________

Insurance co. address: ______________ Insurance co. phone: ______________

Policy holder's employer: ______________

Do you have dual coverage? ○ Yes ○ No If yes then please fill out information below:

Policy holder's name: ______________ DOB: ______________ Social security #: ______________

Insurance company: ______________ Group #: ______________ Union local #: ______________

Insurance co. address: ______________ Insurance co. phone: ______________

Policy holder's employer: ______________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ______________

Updates (date & initial) ______________

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Dental History

Is your child currently in pain? ◯ Yes ◯ No Primary reason for today's visit: ____

Has your child experienced problems with past dental work? ◯ Yes ◯ No

Does your child brush his/her teeth daily? ____ Floss his/her teeth daily? ____

Previous/Present dentist: ____ Date of last visit: ____

Why did you leave your previous dentist? ____

What did you like most about any dentist you have seen? ____ Least? ____

Does/did your child have any of the following habits?

◯ Lip sucking/Biting
◯ Nail biting
◯ Chewing on objects
◯ Clenching/Grinding teeth
◯ Thumb/Finger sucking
◯ Nursing bottle habits
◯ Tongue/Cheek biter
◯ Used pacifier
◯ Tongue thrust
◯ Mouth breather
◯ Speech problems
◯ Breast feeding

Medical History

Child's physician: ____ Phone #: ____ Date of last visit: ____

Address: ____
street city state zip

Is your child currently under the care of a physician? ◯ Yes ◯ No Please explain: ____

Describe your child's current physical health: ◯ Good ◯ Fair ◯ Poor Are immunizations current? ◯ Yes ◯ No

Please list all drugs that your child is currently taking: ____

Please list all drugs and/or things that cause your child allergic reactions: ____

Has your child had/experienced any of the following?

◯ Abnormal bleeding
◯ AIDS/HIV+
◯ Allergies
◯ Anemia
◯ Asthma
◯ Blood transfusion
◯ Cancer
◯ Chicken pox
◯ Congenital heart defect
◯ Convulsions
◯ Diabetes
◯ Epilepsy
◯ Handicaps/Disabilities
◯ Hearing impairment
◯ Heart murmur
◯ Hemophilia
◯ Hepatitis
◯ High blood pressure
◯ Hives
◯ Hospital stay/Operations
◯ Kidney problems
◯ Liver problems
◯ Low blood pressure
◯ Lupus
◯ Measles
◯ Mitral valve prolapse
◯ Mononucleosis
◯ Rheumatic fever
◯ Scarlet fever
◯ Sickle cell anemia
◯ Skin rash
◯ Tonsilitis
◯ Tuberculosis

Please discuss any serious medical problems your child has had/experienced: ____

____

Emergency Information

Name of nearest relative not living with you: ____

Complete address: ____

Phone: ____ Relationship: ____