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ABOUT YOUR CHILD

Today's Date:_____

Child's Name:_____ ☐ Male ☐ Female

Nickname:_____ Birthdate:_____ Age:_____

Home Address:_____ Years @ address:____ Home Phone:_____

School: _____ Grade:_____ Does your child want his/her teeth straightened?_____

Other family members seen by us:_____

Whom may we thank for referring you to our office?_____

Who will be financially responsible for your child's treatment?_____

PARENT INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If divorced or separated, who has primary custody? ☐ Mother ☐ Father

Name:_____

Relationship to Patient:_____

Email:_____

Cell #:_____

Work #:_____

Social Security #:_____DOB:___/___/____

Occupation:_____

Employer:_____

Employer's Address:_____

_____ # years employed:_____

Name:_____

Relationship to Patient:_____

Email:_____

Cell #:_____

Work #:_____

Social Security #:_____DOB:___/___/____

Occupation:_____

Employer:_____

Employer's Address:_____

_____ # years employed:_____

ORTHODONTIC DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name:_____

Employer:_____

Insurance Company:_____

Ins. Co. Address:_____

Ins. Phone #:_____

Group #:_____

Member ID: _____

SECONDARY INSURANCE

Insured's Name:_____

Employer:_____

Insurance Company:_____

Ins. Co. Address:_____

Ins. Phone #:_____

Group #:_____

Member ID: _____

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

PARENT SIGNATURE:_____Date:_____

FOR OFFICE USE ONLY
Date:_____ Age:_____

FAMILY INFORMATION

Patient:_____ Nickname:_____

Brothers' Names and Ages:_____

Sisters' Names and Ages:_____

MEDICAL HISTORY

Patient's Doctor:_____ Date Last Physical Exam:_____

General Health: ☐ Good ☐ Fair ☐ Poor

Does your child have any history of major illness? ☐ Yes ☐ No

If yes, please explain:_____

Does your child need to be pre-medicated before dental treatment: ☐ Yes ☐ No

List all drugs and/or medication being taken and reasons:_____

List any drug sensitivities:_____

Has your child reached puberty?_____ Females: Has menstruation started? _____ Age:_____

Males: Has voice changed? _____ Age:_____

Please check if your child has or had any of the following diseases or medical problems:

- ☐ ADD
- ☐ Alcohol /Drug Abuse
- ☐ Allergies / Sinus Trouble
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Emotional / Mental Illness
- ☐ Endocrine Problems
- ☐ Epilepsy / Seizures
- ☐ Frequent Headaches
- ☐ Heart Murmur / Defects
- ☐ Hepatitis / Jaundice
- ☐ Hemophilia / Abnormal Bleeding
- ☐ HIV Positive / AIDS
- ☐ Hives / Skin Rash
- ☐ Lethargy
- ☐ Rheumatic Fever
- ☐ Sleep Apnea or Excessive Snoring
- ☐ Tonsils / Adenoids Removed
- ☐ Tuberculosis
- ☐ Ulcers

Other serious illness:_____

DENTAL HISTORY

Patient's Dentist:_____ Date Last Dental Exam:_____

Address:_____ Phone:_____

Please check if your child has or had any of the following conditions:

- ☐ Bleeding Gums
- ☐ Canker Sores
- ☐ Chewing Difficulties
- ☐ Clicking or Popping Jaw
- ☐ Grinding of Teeth
- ☐ Herpes / Cold Sores
- ☐ Injuries to Face, Mouth or Teeth
- ☐ Missing or Extra Teeth
- ☐ Mouth Breathing, Awake or Asleep
- ☐ Sensitive Teeth
- ☐ Speech Problems
- ☐ Thumb / Finger Sucking
- ☐ Tongue Thrusting

HAS EITHER PARENT HAD:

- ☐ Orthodontic Treatment
- ☐ Similar Problem
- ☐ Teeth Removed

Has an orthodontist been consulted previously? ☐ Yes ☐ No If yes, doctor's name:_____

What is the main concern about your child's teeth? _____

Is your child worried about orthodontic treatment? ☐ Yes ☐ No

Is your child under any unusual stress at home or school? ☐ Yes ☐ No

EMERGENCY INFORMATION

Name:_____ Relationship to patient:_____

Address:_____

Home Phone:_____ Cell Phone:_____

PARENT SIGNATURE:_____ Date:_____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC & ADA.