Welcome

To Your Orthodontist!

Today's Date: _____

Child's Name:

_____
Last First MI

Nickname: _____ □ Male □ Female

Child's Birthdate: _____/_____/_____Child's Age: _____

Child's Home Phone #: (____)_____

Child's Home Address:

_____

_____
City State Zip

E-Mail Address: _____

School: _____Grade: _____

Hobbies/Sports: _____

Other Siblings/Ages: _____

Who is responsible for the account?

□ **Father** □ Step Father □ Guardian

Name: _____
Last First MI

Address (if different from Child's):

_____

_____
City State Zip

Phone #: (____)_____ Cell#: (____)_____

Birthdate: ____/_____/____ SS#: _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Work #: (_____)_____

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: _____Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Who is accompanying the child today?

Name: _____ Relation:_____

Do you have legal custody of this child? □ Yes □ No

Whom may we thank for referring you?

_____

General Dentist: _____

Last Visit Date: _____

Relative or Friend not living with you:

Name: _____

Phone #: (_____)_____

Parent's Marital Status:

□ Single □ Married □ Partnered □ Widowed □ Divorced □ Separated

□ **Mother** □ Step Mother □ Guardian

Name: _____
Last First MI

Address (if different from Child's):

_____

_____
City State Zip

Phone #: (____)_____ Cell#: (____)_____

Birthdate: ____/_____/____ SS#: _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Work #: (_____)_____

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: _____Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Dental & Medical History

What are the main concerns you would like Orthodontics to accomplish? _____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? □Yes □No

Have there been any injuries to the face, mouth, teeth or chin? □Yes □No

Have adenoids or tonsils been removed? □Yes □No

Does your child have any missing or extra permanent teeth?

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □Yes □No

Does the child brush his/her teeth daily? □Yes □No

Floss his/her teeth daily? □Yes □No

Child's Physician: _____

Phone #: (___)_____ Date of Last Visit:_____

Is the child currently under the care of a physician? □Yes □No

Has puberty begun? □Yes □No

Has menstruation begun? □Yes □No

Please describe the child's current physical health:

□ Good □ Fair □ Poor

Please list all drugs that the child is currently taking:

_____

Aside from items listed below, list all drugs/things your child is allergic to: _____

_____

□Y □N Latex □Y □N Nickel/Metals □Y □N Plastic

List Any Musical Instruments Played: _____

_____

Has the child experienced the following medical problems?

□Yes □No Abnormal Bleeding
□Yes □No ADD/ADHD
□Yes □No AIDS/HIV+
□Yes □No Any Hospital Stays or Operations
□Yes □No Artificial Bones/Joints/Valves
□Yes □No Asthma
□Yes □No Cancer
□Yes □No Congenital Heart Defect
□Yes □No Convulsions
□Yes □No Diabetes
□Yes □No Epilepsy
□Yes □No Handicaps/Disabilities
□Yes □No Hearing Problems
□Yes □No Heart Murmur
□Yes □No Hemophilia
□Yes □No Hepatitis
□Yes □No Kidney Problems
□Yes □No Liver Problems
□Yes □No Mitral Valve Prolapse
□Yes □No Prosthetics
□Yes □No Rheumatic Fever
□Yes □No Scarlet Fever
□Yes □No Sickle Cell Disease/Traits
□Yes □No Tuberculosis (TB)

Anything you would like to discuss with the doctor in private? □Yes □No

Please discuss any serious medical problems the child has had:

_____

_____

_____

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

□Yes □No Clenching/Grinding Teeth
□Yes □No Lip Sucking/Biting
□Yes □No Mouth Breather
□Yes □No Nail Biting
□Yes □No Speech Problems
□Yes □No Thumb/Finger Sucking
□Yes □No Tongue Thrust
□Yes □No Used Pacifier

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

_____

Signature of Parent or Guardian Date