

WELCOME

To the Orthodontist

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

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

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo # _____

City State Zip

Present / Past Dentists: _____

General Information

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? _____

Other siblings seen by us: _____

Relative or Friend not living with you:
Name: _____ Phone: (____) _____

Address: _____
City State Zip

Person Responsible for Account: _____

Parent's Information

Parent's Marital Status Single Married Widowed Divorced Separated

Father Step Father Guardian

Please Circle: Mr. Dr. Rev.

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's)

SS #: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Email: _____ Cell/Other #: (____) _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:
Insurance Co. Name: _____
Insurance Address: _____
City State Zip

Insurance Phone: (____) _____
Group # (Plan, Local, or Policy #): _____

Mother Step Mother Guardian

Please Circle: Mrs. Ms. Dr. Rev.

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's)

SS #: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Email: _____ Cell/Other #: (____) _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:
Insurance Co. Name: _____
Insurance Address: _____
City State Zip

Insurance Phone: (____) _____
Group # (Plan, Local, or Policy #): _____

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Dental & Medical History

What are the main concerns that 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

Does the child require antibiotics before dental treatment? Yes No

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

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:

Please list all drugs/things that the child is allergic to:

Has the child experienced the following medical problems?

- | | |
|------------------------------------|----------------------------|
| Y N Abnormal Bleeding | Y N Epilepsy |
| Y N ADD/ADHD | Y N Handicaps/Disabilities |
| Y N AIDS / HIV+ | Y N Hearing Impairment |
| Y N Allergic to Latex / Metals | Y N Heart Murmur |
| Y N Allergic to Plastic | Y N Hemophilia |
| Y N Allergies to any Drugs | Y N Hepatitis |
| Y N Any Hospital Stays/Operations | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Problems |
| Y N Asthma | Y N Mitral Valve Prolapse |
| Y N Cancer | Y N Prosthetics |
| Y N Congenital Heart Defect | Y N Rheumatic Fever |
| Y N Convulsions | Y N Scarlet Fever |
| Y N Diabetes | Y N Tuberculosis (TB) |

Has the child ever taken any diet pills such as Phen-Fen? Yes No
(Also known as Redux or Pondimin.) If so, when? _____

Are the child's immunizations current? Yes No

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?

- | | |
|------------------------------|---------------------------|
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking/Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb/Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |
| | Y N Used Pacifier |

List any musical instruments played: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

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 services my child may need.

Signature of Parent or Guardian

Date

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist

Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? Y N

If Yes, please explain. _____

Has there been any change in your child's health status since their last visit? Y N

If Yes, please explain. _____

Parent/Guardian Signature

Date

Dentist Signature

Date

Parent/Guardian Signature

Date

Dentist Signature

Date