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 #): _____

Continued on Back

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