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We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Today's Date _____

Patient Information - Child or Teen

Child's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ ❒ Male ❒ Female Home Phone _____

Patient's Home Address _____ City _____ State _____ Zip _____

School _____ Hobbies _____

Who is completing this form? _____
First Middle Last

Relationship _____ Do you have legal custody? ❒ Yes ❒ No

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? ❒ Yes ❒ No If Yes, name _____

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

Has your child visited an orthodontist before? ❒ Yes ❒ No If Yes, for what reason? _____

Is there anything you would like to discuss with the doctor in private? ❒ Yes ❒ No

Parent Information

Marital Status of Parents: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Domestic Partner

Father

❒ Father ❒ Step Father ❒ Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birth Date _____

Social Security Number _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Employer's Address _____

If you have Dental Insurance coverage for the child, please fill out:

Insurance Company Name & Address _____

Insurance Company Phone _____ Group # _____ Insured ID # _____

Mother

❒ Mother ❒ Step Mother ❒ Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birth Date _____

Social Security Number _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Employer's Address _____

If you have Dental Insurance coverage for the child, please fill out:

Insurance Company Name & Address _____

Insurance Company Phone _____ Group # _____ Insured ID # _____

Please complete both sides.

Dental and Medical History

Is the child currently under the care of a physician? ❒ Yes ❒ No If Yes, for what reason?_____

Child's Physician_____ Phone _____

History of major illness? ❒ Yes ❒ No If Yes, please describe _____

Any sensitivities or allergies? ❒ Yes ❒ No If Yes, please list _____

Currently taking any medications? ❒ Yes ❒ No If Yes, please list _____Amount/Dose _____

Has puberty begun? ❒ Yes ❒ No

Has menstruation (period) begun? ❒ Yes ❒ No ❒ Not applicable

Does the child require antibiotics before dental treatment? ❒ Yes ❒ No If Yes, explain _____

Have the adenoids or tonsils been removed? ❒ Yes ❒ No

Have you been informed of any missing or extra permanent teeth? ❒ Yes ❒ No

Have there been injuries to the child's face, mouth or chin? ❒ Yes ❒ No

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Check (☑) if your child ever had any of the following medical problems:

- ❒ Abnormal Bleeding
- ❒ ADD/ADHD
- ❒ Allergies to any Drugs
- ❒ Allergic to Latex / Metals
- ❒ Allergic to Plastic
- ❒ Any Hospital Stays
- ❒ Any Operations
- ❒ Asthma
- ❒ Autistic
- ❒ Cancer
- ❒ Congenital Heart Defect
- ❒ Convulsions / Epilepsy
- ❒ Diabetes
- ❒ Handicaps / Disabilities
- ❒ Hearing Impairment
- ❒ Heart Murmur
- ❒ Hemophilia
- ❒ Hepatitis
- ❒ HIV positive / AIDS
- ❒ Kidney / Liver Problems
- ❒ Rheumatic / Scarlet Fever
- ❒ Tuberculosis

Check (☑) if your child has any of the following habits:

- ❒ Clenching / Grinding Teeth
- ❒ Lip Sucking / Biting
- ❒ Mouth Breather
- ❒ Nail Biting
- ❒ Nursing Bottle Habits
- ❒ Speech Problems
- ❒ Thumb / Finger Sucking:
  Active *(circle one)* yes no
- ❒ Tongue Thrust

Please discuss any medical problems that your child has had:

_____

_____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein. Initials _____ Date_____

Doctor's Comments:

_____

_____

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_____

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