FOR CHILDREN: WELCOME TO OUR PRACTICE!

1) TELL US ABOUT YOUR CHILD

Today's Date: _____ DOB: _____

Child's Name: AGE: _____

_____

Last **First** **M.I.**

Nickname: _____ Gender: **M | F**

School: _____ Grade: _____

Home phone #: _____

Child's Home Address:

_____

Street **Apt #**

_____

City **State** **Zip**

Siblings:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

2) WHO IS WITH THE CHILD TODAY?

Name: _____

Relationship: _____

Are you the legal guardian? **Yes | No**

Parent's Marital Status: **Single | Married | Divorced**

Who may we THANK for referring you? _____

Any other family members seen by us? _____

_____

Family Dentist's Name: _____

Street: _____

Phone #: _____ Last visit: _____

3) MOTHER'S INFORMATION

Name: _____

WK #: _____ Ext. _____ Cell: _____

Employer: _____

DL #: _____ State: _____

SS #: _____- _____ - _____

FATHER'S INFORMATION

Name: _____

WK #: _____ Ext. _____ Cell: _____

Employer: _____

DL #: _____ State: _____

SS #: _____- _____ - _____

4) RESPONSIBLE PARTY INFORMATION

Name: _____

Billing Address : _____

_____

City **State** **Zip**

WK #: _____ Ext. _____ Cell: _____

Email: _____

Employer: _____

DL #: _____ State: _____

SS #: _____- _____ - _____

Who is responsible for making appointments?

Name: _____

WK #: _____ Ext. _____ Cell: _____

HM #: _____

5) PRIMARY DENTAL INSURANCE

Insurance Name: _____

Ins. Address: _____

_____

Ins. Co. Phone #: _____

Group/Policy #: _____

ID #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

Insured's SS #: _____- _____ - _____

Orthodontic Coverage: **Yes | No**

SECONDARY DENTAL INSURANCE

Insurance Name: _____

Ins. Address: _____

_____

Ins. Co. Phone #: _____

Group/Policy #: _____

ID #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

Insured's SS #: _____- _____ - _____

Orthodontic Coverage: **Yes | No**

PLEASE COMPLETE BOTH SIDES

6) Why did you bring the child to the Orthodontist?

My concern(s): _____

Is the child also concerned about the teeth? **Y | N**

Has the child ever had a serious/difficult problem with dental work? **Y | N**

Does the child brush his/her teeth daily? **Y | N**

Does the child floss daily? **Y | N**

Has the child ever had any pain or soreness in the jaw joint (TMJ/TMD)? **Y | N**

Describe any previous ortho treatment or consultations:

_____

Describe the child's general health. **Good | Fair | Poor**

Is the child currently under a physician's care? **Y | N**

Please list all medications the child is currently taking:

_____

Please list any drug allergies: _____

_____

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

7) MEDICAL HISTORY

Y | N	Heart Murmur	**Y | N**	Congenital Heart Defect
Y | N	Cancer	**Y | N**	Epilepsy/Seizures
Y | N	Diabetes	**Y | N**	Mental Health Problems
Y | N	Rheumatic Fever	**Y | N**	Bleeding Disorders
Y | N	Scarlet Fever	**Y | N**	Hearing Impairments
Y | N	Asthma	**Y | N**	Any Operations
Y | N	Hepatitis	**Y | N**	Arthritis/Joint Problems
Y | N	Tuberculosis	**Y | N**	Handicaps/Disabilities
Y | N	Prosthesis	**Y | N**	Kidney/Liver Problems
Y | N	HIV/AIDS	**Y | N**	Facial/Neck Injuries

Describe any serious medical condition(s): _____

_____

8) DENTAL HABITS

Y | N Thumb/finger sucking If Yes, to what age? _____

Y | N Lip sucking/biting: _____

Y | N Nail biting: _____

Y | N Nursing bottle cavities: _____

Y | N Snoring: _____

Y | N Mouth breathing: _____

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

_____

Signature of parent/guardian Date

** The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

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

Initials: _____ Date: _____

Doctor's comments: _____

_____

Medical History Update:

1. Date _____ Signature: _____

Comments: _____

2. Date _____ Signature: _____

Comments: _____