PATIENT INFORMATION - CHILD

ALL ABOUT YOUR CHILD

PATIENT'S NAME____ NICKNAME ____________________
LAST FIRST MI

MALE _____ FEMALE _____ BIRTHDATE ______________ AGE _____ SCHOOL ____________________ GRADE ___________

HOBBIES/SPORTS ____

CHILD'S RESIDENCE ____
STREET CITY ZIP

CHILD'S HOME PHONE ______________________ EMAIL ____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

NAME ____________________________________ RELATION _______________________________________

PARENTS MARITAL STATUS ______________________ DO YOU HAVE LEGAL CUSTODY OF THIS CHILD____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

OTHER FAMILY MEMBERS SEEN BY US? ____

◯ MOTHER ◯ STEP MOTHER ◯ GUARDIAN

NAME ____ EMPLOYER____

CELL # _______________________ HOME # _______________________________ WORK # ______________________

RESIDENCE ____
STREET CITY ZIP

EMAIL ____D.O.B. ____________ HOW LONG AT CURRENT JOB? ___________

TITLE ________________________ DO YOU HAVE DENTAL INSURANCE WITH ORTHODONTIC COVERAGE?__________________

◯ FATHER ◯ STEP FATHER ◯ GUARDIAN

NAME ____ EMPLOYER____

CELL # _______________________ HOME # _______________________________ WORK # ______________________

RESIDENCE ____
STREET CITY ZIP

EMAIL ____ D.O.B. ____________ HOW LONG AT CURRENT JOB? ___________

TITLE ________________________ DO YOU HAVE DENTAL INSURANCE WITH ORTHODONTIC COVERAGE?__________________

WHO WILL BE RESPONSIBLE FOR MAKING APPTS?__________ WHO WILL BE RESPONSIBLE FOR THE ACCOUNT? ___________

DO YOU PREFER EMAIL OR TEXT MESSAGE REMINDERS FOR UPCOMING APPOINTMENTS?: EMAIL TEXT MSG

DENTAL HISTORY

GENERAL DENTIST____DATE OF LAST VISIT_____________________________

WHAT ARE YOUR MAIN CONCERNS THAT YOU WOULD LIKE TO WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

____

DOES YOUR CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING TRAITS?

Y/N CLENCHING/GRINDING Y/N NAIL BITING Y/N MOUTH BREATHER Y/N SODA POP DRINKER
Y/N LIP SUCKING/BITING Y/N THUMB/FINGER SUCKER Y/N TONGUE THRUSTER Y/N BLEEDING GUMS

Yes No Has your child ever been evaluated for orthodontic treatment?
Yes No Has your child ever been informed of any missing or extra permanent teeth?
Yes No Does your child brush his/her teeth daily?
Yes No Floss his/her teeth daily?
Yes No Has puberty begun?
Yes No Has menstruation begun? (Girls)
Yes No Have you ever had a serious problem with your child's previous dental work?
Yes No Have you ever lost or chipped any teeth?
Yes No Has there ever been any injury to the: face/mouth/teeth/chin?
Yes No Has anyone in your family received orthodontic treatment?
How did they feel about the result?____

____
Yes No Does your child now or have they ever experienced pain or discomfort in their jaw joint (TMJ)?
Yes No Are you aware that some appointments will be during work/school hours?

Your child's current dental health is: ◯ Good ◯ Fair ◯ Poor

MEDICAL HISTORY

Child's Physician ________________________________ Date of Last Visit__________________________

Phone __________________________ Is your child currently under the care of a physician? _______________

Your child's current medical condition is: ◯ Good ◯ Fair ◯ Poor

Please list all medications your child is currently taking ____

Please list all medications/materials your child is allergic to ____

Circle any of the medical conditions below that your child has had or currently has:

Abnormal bleeding
ADD/ADHD
Anemia
Arthritis
Artificial Bones/Joints
Asthma or Hayfever
Bone Disorders
Congenital Heart Defect
Diabetes
Difficulty Breathing
Dizziness
Depression/Anxiety
Epilepsy
GI Disorders
Handicaps/Disabilities
Hearing Impairment
Heart Murmur
Heart Problems
Hepatitis
Herpes/Fever Blisters
High/Low Blood Pressure
HIV / Aids
Kidney problems
migraines/headaches
Nervous Disorders
Pneumonia
Radiation/Chemo/Cancer
Sinus Problems

Are there any medical conditions we have not discussed that you feel we should be aware of?_______________

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DENTAL INSURANCE INFORMATION

Insured's Name______________________ D.O.B. __________Insured's SS #/ID# ______________________

Insurance Company____________________ Group No.__________ Plan No. ___________________________

Insurance Co Phone No. ______________________________ Employer ______________________________

Do you have dual coverage? Yes____ No____ If yes:

Insured's Name______________________ D.O.B__________ Insured's SS #/ID# ______________________

Insurance Company____________________ Group No.__________ Plan No. ___________________________

Insurance Co Phone No. ______________________________ Employer ______________________________

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. *In addition, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

Signature: ________________________________Date: ____________________