WELCOME TO OUR PRACTICE

Child's Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Nick Name:_____ □**MALE** □**FEMALE**
NAME THEY WOULD LIKE TO BE CALLED

Home Address:_____ **School:**_____
STREET

_____ **Grade:**_____
CITY STATE ZIP

Phone: (___)_____ **Cell: (___)**_____ **Referred By**_____

Mother's Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Mailing Address:_____ **DL#**_____
(IF DIFFERENT) STREET

_____ **SSN#**_____
CITY STATE ZIP

E-Mail:_____ **Employer**_____

Phone: (___)_____ **Cell: (___)**_____ **Work: (___)**_____

Father's Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Mailing Address:_____ **DL#**_____
(IF DIFFERENT) STREET

_____ **SSN#**_____
CITY STATE ZIP

E-Mail:_____ **Employer**_____

Phone: (___)_____ **Cell: (___)**_____ **Work: (___)**_____

Responsible Party Information

Name:_____ **DOB:**_____ **AGE:**_____
LAST FIRST MI

Mailing Address:_____ **DL#**_____
(IF DIFFERENT) STREET

_____ **SSN#**_____
CITY STATE ZIP

E-Mail:_____ **Employer**_____

Phone: (___)_____ **Cell: (___)**_____ **Work: (___)**_____

Insured Name_____ Insurance Co_____

Insured Address_____ Insurance #_____

_____ Group#_____

Insured SSN #_____ Relation to patient_____

DOB_____ _____

Employer_____

Insured Name_____ Insurance Co_____

Insured Address_____ Insurance #_____

_____ Group#_____

Insured SSN #_____ Relation to patient_____

DOB_____ _____

Employer_____

Dental Questions

Why did you bring your child to the orthodontist today?_____

_____

_____

Has your child ever had a serious/difficult problem associated with dental work? □Y □N
Please Explain_____
Has your child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? □Y □N
Does your child brush his/her teeth daily? □Y □N
Floss his/her teeth daily? □Y □N

Current Dentist:_____ Last Visit_____

Medical Questions

Childs Physician:_____ Phone #_____ Last Visit:_____

Is your child currently under the care of a Physician? □Y □ N

Please describe child's health: □ GOOD □ FAIR □POOR

Please list any medication/drugs your child is currently taking:_____

_____

Please list any allergies to medications:_____

Is your child allergic to any of the following?

□Y □N Aspirin □Y □N Erythromycin
□Y □N Codeine □Y □N DentalAnesthetics
□Y □N Latex □Y □N Tetracycline
□Y □N Penicillin □Y □N Other:_____

Any of the following habit's or symptoms?

□Y □N Thumb, Nail, or Lip Habits
□Y □N Bed Wetting
□Y □N Bruxing (grinding of teeth)
□Y □N Snoring
□Y □N Morning Headaches
□Y □N Hyperactivity
□Y □N Excessive Daytime Sleepiness
□Y □N Poor School Performance
□Y □N Inward movement of the rib cage during sleep (paradoxical breathing)

Has your child had any of the following diseases or medical problems?

□Y □N Prosthesis
□Y □N Heart Attack
□Y □N Cancer
□Y □N Diabetes
□Y □N HIV/AIDS
□Y □N Hemophilia
□Y □N Asthma
□Y □N Hepatitis
□Y □N Tuberculosis
□Y □N Shingles
□Y □N Fever Blister
□Y □N Venereal Dis
□Y □N Ulcers/Colitis
□Y □N Heart Murm
□Y □N Emphysema
□Y □N Sinus Probs
□Y □N Scarlet Fever
□Y □N Congenital Heart Def
□Y □N Convulsions/Epilepsy
□Y □N Abnormal Bleeding
□Y □N Artificial Valves
□Y □N Heart Surgery
□Y □N Any stays in the hospital
□Y □N Kidney/Liver Problems
□Y □N Hey/Freq Headaches
□Y □N Drug/Alcohol abuse
□Y □N Blood Transfusion
□Y □N Anemia
□Y □N Glaucoma
□Y □N Difficulty breathing
Other_____
_____

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

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical 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 time of service unless prior arrangements have been approved.

OFFICE USE ONLY:
I verbally reviewed the dental/medical information above with parent/guardian & patient named herein.
Initial_____ **Doctors Comments**_____