

WELCOME TO OUR OFFICE

CHILD PATIENT INFORMATION

Name: _____ Prefer to be called: _____ Sex: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Patient resides with: Mother Father Both Other: _____

Home Phone: _____ Age: _____ Birthdate: _____ Social Security#: _____ - _____ - _____

Patient's Dentist: _____ School: _____ Grade: _____

Describe your child's orthodontic problem: _____

Patient's interests: _____

Whom may we thank for referring you to our office? _____

Parents and Account Information

Parent's Marital Status: Married Separated Divorced Widowed

FATHER

MOTHER

Name: _____

Address (if different than above) _____

Phone (if different than above) _____

Social Security Number: _____

Employer's Name: _____

Business Address: _____

Business Phone: _____

Occupation: _____

How long with this employer: _____

Person responsible for account: _____

If other than parent:

Name: _____ Address: _____ Phone: _____

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee): _____

Date of Birth: _____ Social Security# _____ - _____ - _____

Name of insurance company: _____ Group #: _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name: _____ Address: _____ Phone: _____

Has your child experienced any health problems? No Yes Explain: _____
 Any major change in your child's health recently? No Yes Explain: _____
 Is your child currently under a physician's care? No Yes Explain: _____
 Is your child currently taking any medications? No Yes Explain: _____
 Is your child allergic to any medications? No Yes Explain: _____
 Has your child received a blood transfusion? No Yes Explain: _____
 Have your child's tonsils or adenoids been removed? No Yes Explain: _____

Please check if your child has had any of the following conditions:

Heart Murmur.....	No	Yes	Hepatitis.....	No	Yes	Emotional Problems....	No	Yes
Heart Surgery.....	No	Yes	Diabetes.....	No	Yes	Frequent Headaches....	No	Yes
Rheumatic Fever.....	No	Yes	Kidney Disease...	No	Yes	Nervous/Anxious.....	No	Yes
Endocrine disorders.....	No	Yes	Liver Disease.....	No	Yes	Cancer.....	No	Yes
Prolonged Bleeding.....	No	Yes	Tuberculosis.....	No	Yes	Bone Disorders.....	No	Yes
Anemia.....	No	Yes	Bronchitis.....	No	Yes	Growth Disorders.....	No	Yes
Blood Disease.....	No	Yes	Asthma.....	No	Yes	Mouth Breather.....	No	Yes
Developmental Disorder.	No	Yes	Epilepsy.....	No	Yes	Herpes (Fever Blisters).	No	Yes
Hives/Rash.....	No	Yes	Fainting.....	No	Yes	Tonsillitis.....	No	Yes

Is there any other condition or problem that you think we should know about? _____

Growth Information for Patients Under 16 Years of Age:

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in selection of treatment alternatives.

Has your son or daughter reached puberty? No Yes
 Girls- Has she started menstruation? No Yes When? _____
 Boys- Has his voice changed? No Yes When? _____
 Father's Height _____ Mother's Height _____ Adopted No Yes
 Names and Birthdates of patient's brothers and sisters: _____
 Have either siblings or parents had orthodontic treatment? No Yes With Whom? _____

Dentist's Name: _____ Address: _____ Phone: _____

Dental checkups: 2 times a year 1 time a year Only if problem exists Never Date of Last Visit: _____
 Is there any unfinished care to be completed with your child's dentist? No Yes Explain: _____
 Is your child frightened about dental treatment? No Yes Explain: _____
 Has your child had an unpleasant experience in the dental office? No Yes Explain: _____
 Has your child had any facial or dental injuries? No Yes Explain: _____
 Is there any history of thumb or finger sucking? No Yes Explain: _____
 Does your child play any musical instruments? No Yes Explain: _____
 Has your child consulted an orthodontist previously? No Yes Explain: _____
 Have teeth (either primary or permanent) been removed? No Yes Explain: _____
 Has your child had any previous orthodontic treatment? No Yes Explain: _____
 Are you satisfied with prior treatment? No Yes Explain: _____
 Any changes in your child's bite or dental alignment recently? No Yes Explain: _____

Please check if there is a history of:

Clenching teeth	Muscular Soreness around head & neck	Jaw joint soreness	Jaw joint popping
Grinding teeth	Headaches (more than normal)	Jaw joint clicking	Ringing in the ears
Speech problems (if so what sounds _____)	Mouthbreathing	Awake _____	Asleep _____

Is there any other information which may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

Parent Signature **Date** **Reviewed by**