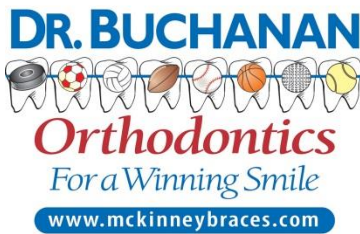

Tell us about your child

Date: ___________________________

Patient Name: _______________________________________ Birthday: _________________ Sex: ☐ M ☐ F

Address: _______________________________________ City: _______________ State: _______ Zip Code: ________

School: ____ Grade: _______

Dentist: _______________________________________ Last Cleaning: _________________________________

Mothers Information or legal guardian

Name: ____ Date of Birth: _____________ SS#: ______________________

Address: _______________________________________ City: _______________ State: _______ Zip Code: ________

Cell Phone: ________________ Work Phone: ________________ E-Mail:_____________________________________

Employer: _______________________________________ Occupation: _______________________________________

Father's Information or legal guardian

Name: ____ Date of Birth: _____________ SS#: ______________________

Address: _______________________________________ City: _______________ State: _______ Zip Code: ________

Cell Phone: ________________ Work Phone: ________________ E-Mail:_____________________________________

Employer: ____________________________________ Occupation: _______________________________________

Who is the legal guardian of this patient? ____

Who is financially responsible for this patient? ☐ Mother ☐ Father ☐ Both ☐ Other _________________________

If both, will it be equal responsibility? ☐ Y ☐ N If no, please explain: ______________________________________

Parents' Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for recommending our services? _______________________________

<u>Dental Insurance Information</u>

Insured's Name____________________________ Date of Birth _______________ Insured's SSN______________________

Employer ____Insurance Co. ____

ID/Member # ________________________ Group # _______________________ Insurance Phone #____________________

Additional Information

Main reason for seeking treatment: ____

Is there anything else that you feel we should know about the patient that may be helpful for consultation/treatment?
____
List family members that have been treated by this practice: ____
Has patient had previous orthodontic treatment? ☐ Yes ☐ No If so when? _____________________
Has patient had problems with previous dental treatment? ____
Has patient been treated for TMJ?
Does patient need to be pre-medicated before dental treatment?

Medical History

Does the patient have a history of any of the following? Please check all that apply.
Does the patient have any allergies to medicines (drugs) or medical products (latex)? _________________________
List daily medications patient is presently taking: ____
Do you have, or have had, any of the following:

- ☐ Anemia
- ☐ Blood disease
- ☐ Prolonged bleeding
- ☐ Jaundice
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Heart problems
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Bone disorders
- ☐ Epilepsy
- ☐ Herpes
- ☐ Frequent colds/flu
- ☐ Frequent tonsillitis
- ☐ **Tonsils removed: Age_________**
- ☐ **Adenoids removed: Age_______**
- ☐ Asthma
- ☐ Mouth Breathing: Awake / Asleep
- ☐ H I V positive

Explain any checked: ____

Dental History

Please check any that apply:

- ☐ Any head, face, or tooth injuries, Explain:____
- ☐ History of thumb/finger sucking? Is the habit still present? Y / N If no, stopped at what age?_______________
- ☐ Previous orthodontic consultation or treatment? If so, when?____
- ☐ Any speech problems? Explain:____
- ☐ Clenching of teeth
- ☐ Muscular soreness (head / neck)
- ☐ Jaw soreness
- ☐ Ringing in the ears
- ☐ Grinding of teeth
- ☐ Frequent headaches
- ☐ Jaw clicking/popping
- ☐ Difficulty opening/closing

Explain any checked item(s): ____
Realizing that successful treatment greatly depends upon your cooperation in following instructions, keeping appointments and maintaining oral hygiene.

Are there any restriction, handicaps, or problems that might be encountered during treatment? ☐ Yes ☐ No
If yes please explain: ____

Person completing this form: ____________________________Relationship to patient: ___________________

Thank you! We're glad you're here!