CHILD PATIENT INFORMATION

Date ______________________ Pt# __________ Chrt # __________

Patient's Name: ______________________ Male / Female Birthdate __________ Age __________
First Middle Last Nickname

Address ______________________ Phone __________
Street City ST Zip

School __________ Grade ______ Email: __________

Patient's Dentist __________ Whom may we thank for referring you? __________

Names of siblings __________ Hobbies & Interests __________

Has any member of family undergone Orthodontic Treatment? Y / N Who & Where? __________

Patient's legal guardian's name? __________ Who is responsible for making appointments? __________

RESPONSIBLE PARTY INFORMATION

Name: ______________________ Marital Status: S / M / D
First Middle Last

Address ______________________ Home Phone __________
Street City ST Zip

How long at this address ______ Previous Address (if less than 3 yrs) __________
Street City ST Zip

Social Security # __________ Birthdate ______ Relationship to Patient __________ Cell Phone __________

Employer __________ Work Phone __________ No. Years Employed ____

PARENT INFORMATION - If Different from Responsible Party

Father's Name: ______________________ Marital Status: S / M / D
First Middle Last

Address ______________________ Home Phone __________
Street City ST Zip

Social Security # __________ Birthdate ______ Cell Phone __________ Parent / Step-parent / Guardian

Email: __________ Employer __________ Work Phone __________

Mother's Name: ______________________ Marital Status: S / M / D
First Middle Last

Address ______________________ Home Phone __________
Street City ST Zip

Social Security # __________ Birthdate ______ Cell Phone __________ Parent / Step-parent / Guardian

Email: __________ Employer __________ Work Phone __________

ORTHODONTIC INSURANCE INFORMATION

Primary Policy Holder's Name: __________ S.S.# __________ Birthdate __________

Insured's Employer __________ Occupation __________ Relationship to Patient __________

Work Address ______________________ Work Phone __________
Street City ST Zip

Insurance Company __________ Group No. __________ Phone No. __________

Insurance Company's Address __________ Ins. ID# __________
(OFFICE USE)

Do you have dual coverage? Yes No

Secondary Policy Holder's Name: __________ S.S.# __________ Birthdate __________

Insured's Employer __________ Occupation __________ Relationship to Patient __________

Work Address ______________________ Work Phone __________
Street City ST Zip

Insurance Company __________ Group No. __________ Phone No. __________

Insurance Company's Address __________ Ins. ID# __________
(OFFICE USE)

EMERGENCY INFORMATION

Name ______________________ Relationship to Patient ____________ Phone ____________

Address ______________________________________ Cell Phone ____________

MEDICAL HISTORY

Is Patient in good health? Yes / No Reason: ______________________

Any major or unusual illnesses or surgery? Yes / No Explain: ______________________

List any allergies or drug sensitivities ______________________

Currently taking medication? Yes / No List: ______________________

Has the patient been under the care of a physician during the last two years? Yes / No Explain: ______________________

Name of physician: ______________________

Please check box if patient has or has had any of the following:

- ☐ Adenoids Removed When ________
- ☐ Anemia
- ☐ Asthma or Hay Fever
- ☐ Birth Defects
- ☐ Blood Disease
- ☐ Prolonged Bleeding
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Colds (Frequently)
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Faintness/Dizziness
- ☐ Frequent Cold/Flu
- ☐ Headaches (more than normal)
- ☐ Hearing Disorders
- ☐ Heart Disease or Murmur
- ☐ Hepatitis
- ☐ Herpes/Venereal Disease
- ☐ In the risk group for HIV+ / Aids
- ☐ Jaundice
- ☐ Joint Swelling
- ☐ Kidney Involvement
- ☐ Mononucleosis
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tonsils removed When ________
- ☐ Tuberculosis
- ☐ Other

Explain any: ______________________

Growth Information for Patients Under 16 Years of Age: (the following information helps us determine skeletal maturity)

Father's Height: ________ Mother's Height: ________ Adopted? Y / N Patient resembles: Father Mother Neither Parent

Approximately how much has patient grown in last year? ______________________

Girls: Has menstruation begun? ______ When? ____________ Boys: Has voice change begun? ______ When? ________

Additional comments: ______________________

DENTAL HISTORY

As it pertains to the patient please check box and circle if answer is YES

- ☐ Thumb, finger, lip sucking? Stopped? When ________
- ☐ Chewing or biting nails, objects?
- ☐ Mouth-breathing when asleep, awake?
- ☐ Grinding teeth?
- ☐ A tongue-thrust problem?
- ☐ Any speech problems or therapy?
- ☐ Any pain/soreness, popping/clicking on opening mouth / jaw joint?
- ☐ Muscular Soreness around Head/Neck?
- ☐ Ringing in the ears?
- ☐ High Decay Rate?
- ☐ Any missing permanent teeth?
- ☐ Any extta permanent teeth?
- ☐ Any teeth removed by extraction?

Has the patient had a previous orthodontic consultation Y / N or Treatment? Y / N Date: ________ Dr. ____________

Orthodontic consultation prompted by: Patient Mother Father Dentist Sibling Physician Friend

Has the patient's dentist pointed to an orthodontic problem? ______________________

What do you consider to be the main orthodontic problem? ______________________

What would you like to have orthodontic treatment accomplish? ______________________

Patient's interest in orthodontic treatment: Wants Treatment / Treatment if Necessary / Unwilling but Agrees / Objects to Treatment

Is there any other information that might be helpful? ______________________

Has the patient had any injuries to head, face, jaw, chin, mouth, or teeth? Y / N Explain: ______________________

Has the patient experienced problems with previous dental work? Explain: ______________________

Does the patient visit dentist regularly? ________ Date of last visit: ____________ Date of last dental cleaning: ________

Has the patient received or been requested to receive speech correction? Y / N Explain: ______________________

What is your child's temperament? ______________________

Quality of patient's school work? ____A ____ B ____ C ____ D ____ F

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I understand credit bureau reports will be obtained for financial arrangements.

Signature (Parent's signature if minor) ______________________ **Date** ____________