



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

ABOUT YOUR CHILD

Today's Date: _____
Child's Name: _____
Preferred Name: _____
Home Address: _____

City State Zip
Home #: _____
Birth date: ____/____/____ Age: _____
General Dentist: _____
Date of Last Visit: _____
School: _____
Grade: _____
Hobbies/Sports: _____
Brothers/Sisters with birth dates: _____

WHOM MAY WE THANK FOR REFERRING YOU?

Parent's Information

MOTHER'S INFORMATION

Name: _____
Address: _____
WK# _____ HM# _____

FATHER'S INFORMATION

Name: _____
Address: _____
WK# _____ HM# _____

Who is responsible for making appointments?

Name: _____
WK# _____
HM# _____

Person Responsible for Account

Name: _____ Relation: _____
Address: _____

City State Zip
WK# _____ HM# _____
Employer: _____
SS #: _____

Primary Dental Insurance

Orthodontic Coverage? Yes No
Insured's Name: _____
Relationship to Patient: _____
Insured's Birthday: ____/____/____ Social Security #: _____
Insured's Employer: _____
Employer's Address: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, Local or Policy #): _____

Secondary Dental Insurance

Orthodontic Coverage? Yes No
Insured's Name: _____
Relationship to Patient: _____
Insured's Birthday: ____/____/____ Social Security #: _____
Insured's Employer: _____
Employer's Address: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, Local or Policy #): _____

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What are the main concerns that you would like braces to accomplish?

Has your child ever been evaluated or had orthodontic treatment before?

YES NO

Have there been any injuries to the face, mouth, teeth or chin?

YES NO

Have the adenoids or tonsils been removed?

YES NO

Has your child ever been informed of any missing or extra permanent teeth?

YES NO

Has your child ever experienced pain/tenderness in his/her jaw joint (TMJ/TMD)? YES NO

Does your child Brush his/her teeth daily?

YES NO

Floss his/her teeth daily?

YES NO

Child's Physician: _____

Phone #: _____

Is your child currently under the care of a physician?

YES NO

Has puberty begun? YES NO

Has menstruation begun (Females)? YES NO

Please describe your child's physical health:

Good Fair Poor

Please list all drugs, including over-the-counter medications that your child is currently taking: _____

Please list all drug allergies: _____

Does your child have any of the following Habits?

Y N Thumb / Finger Sucking Y N Mouth Breathing
 Y N Lip Sucking/Biting Y N Speech Problems
 Y N Clenching/Grinding Teeth Y N Nail Biting
 Y N Tongue Thrust

Patient's Height: _____ Weight: _____

Mother's Height: _____ Father's Height: _____

PATIENT'S REACTION TO ORTHODONTIC TREATMENT IS:

EAGER COMPLACENT ANTAGONISTIC

Has your child ever had any of the following

medical problems?

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Seasonal Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Bone Disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N HIV +/-AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Surgeries | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalizations | <input type="checkbox"/> Y <input type="checkbox"/> N Cleft Lip/Cleft Palate |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Emotional Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mono | <input type="checkbox"/> Y <input type="checkbox"/> N Endocrine Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Nutritional Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting or Dizziness |

Please discuss any medical problems that your child has had: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictness of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Parent or Guardian _____ Date _____