

WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Child or Teen

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female Patient's Home Phone _____

Patient's Home Address _____ City, State, ZIP _____
Street

Who is filling in this form? Name _____
First Middle Last

Relationship _____ Do you have legal custody? YES NO

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO If YES, Name _____
First Middle Last

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

Has your child visited an orthodontist before? YES NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

Parents Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Father

Father Step Father Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Mother

Mother Step Mother Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____



ORTHODONTIC, MEDICAL AND DENTAL HISTORY

Your answers to the following questions will be helpful in planning an orthodontic treatment.

Patient's Name: _____ **Date:** _____

1. Date of patient's last dental cleaning & check up: _____ Dentist name: _____

2. Does the patient have an allergy to LATEX? Yes _____ No _____

3. Please list any other allergies: _____

4. Does the patient need any medications prior to dental work? Yes _____ No _____

If so, please list: _____

5. Is the patient presently under a physician's care? Yes _____ No _____

For what? _____

6. Is the patient taking any medication? Yes _____ No _____

What kind? _____

7. Has the patient ever had rheumatic fever? Yes _____ No _____

heart disease? Yes _____ No _____

diabetes? Yes _____ No _____

convulsions? Yes _____ No _____

8. Has the patient experienced any other problems? Yes _____ No _____

Please describe: _____

9. Has the patient been ill for more than 5 days in the last year? Yes _____ No _____

Name of illness: _____

10. Has the patient ever had extensive x-ray therapy? Yes _____ No _____

11. Has the patient experienced a sudden increase in height? Yes _____ No _____

12. If the patient is a male, has his voice changed or has he started to shave? Yes _____ No _____

13. If the patient is a female, has she started her menstrual cycle? Yes _____ No _____

14. Has the patient ever had operations or injuries of the head or neck? Yes _____ No _____

Please describe: _____

15. Has the patient ever had a severe blow on the teeth or jaws? Yes _____ No _____

Please describe: _____

