

FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____
Child's Name: _____ AGE: _____

Last _____ First _____ Mi _____
 Nickname: _____ Male Female
 School: _____ Grade: _____
 Home #: _____
 SS #: _____
Child's Home Address: _____
 _____ Apt# _____
 _____ City _____ State _____ Zip _____
 Siblings:
 Name _____ Age _____
 Name _____ Age _____

2.) WHO IS WITH THE CHILD TODAY?

Name: _____
 Relation: _____
 Do you have legal custody of this child?
 YES _____ NO _____
 Who may we thank for referring you? _____

Other family members seen by us:

Previous/Present Dentist: _____
 Street: _____
 Phone #: _____ Last Visit: _____
 Parent's Marital Status: _____
 (single, married, divorced)

3.) MOTHER'S INFORMATION:

Name: _____
 WK#: _____ Ext. _____ HM#: _____
 Employer: _____
 DL#: _____
 SS#: _____

FATHER'S INFORMATION:

Name: _____
 WK#: _____ Ext. _____ HM#: _____
 Employer: _____
 DL#: _____
 SS#: _____

4.) RESPONSIBLE PARTY INFO:

Name: _____
 Billing address: _____

 City _____ State _____ Zip _____
 WK#: _____ Ext. _____ HM#: _____
 Cell #: _____
 Email: _____
 Employer: _____
 DL#: _____
 SS#: _____

Who is responsible for making appts?

Name: _____
 WK#: _____ Ext. _____ HM#: _____

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____
 Ins. Address: _____

 Insurance Co. Phone #: _____
 Group/Policy # _____

Insured's Name: _____
 Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
 Orthodontic Coverage: YES _____ NO _____

SECONDARY DENTAL INSURANCE

Ins. Name: _____
 Ins. Address: _____

 Insurance Co. Phone #: _____
 Group/Policy # _____

Insured's Name: _____
 Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
 Orthodontic Coverage: YES _____ NO _____

6) Why did you bring the child to the Orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work? Y N

Is the child's water fluoridated? Y N

Is the child taking fluoridated supplements?

Y N

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

Y N

Does the child brush teeth daily? Y N

Floss their teeth daily? Y N

Child's Physician: _____

Phone#: _____ Last visit: _____

Is the child currently under the care of a physician? Y N

Please describe the child's health:

GOOD FAIR POOR

Please list all drugs the child is currently taking: _____

Please list all drugs the child is allergic to: _____

7) Has the child ever had any of the following medical problems?

Y N Heart Murm.

Y N Congenital Heart Def.

Y N Cancer

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Abnormal Bleeding

Y N Rheum. Fev.

Y N Hearing Impairment

Y N HIV+/AIDS

Y N Any Operations

Y N Hemophilia

Y N Any Stays in Hospital

Y N Asthma

Y N Kidney/Liver Problems

Y N Hepatitis

Y N Handicaps/Disabilities

Y N Tuberculosis

Y N Allergies to Any Drugs

Y N Prosthesis

Y N History of Scarlet Fever

Please discuss any serious medical problems that the child has had: _____

8) Does the child have any of the following habits?

Y N Thumb sucking / Finger sucking

Y N Lip sucking / biting

Y N Nail Biting

Y N Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent/guardian _____ Date _____

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____