PATIENT INFORMATION:

Today's Date ________________

Name____ DOB_________________ Age _____________

Address____ Male / Female

City_ __________________________________ State__________ Zip________________

Home#____________________ E-Mail_________________________________ School_________________________

Siblings/Ages_________________________________ Other relatives seen by us:_____________________________

General Dentist______________________________________ Last cleaning visit______________________

Address____________________________________Phone#__________________________

Who is with the child today? Mother / Father / Legal Guardian – Relation _________________________

Who may we thank for referring you? ____

RESPONSIBLE PARTY:

Mother's Name_________________________________ DOB________________ SS#_________________________

Employer__________________________ Work# __________________Ext:_______ Cell#_ _______________________

Father's Name_________________________________ DOB_ ________________ SS#__________________________

Employer__________________________ Work# __________________Ext:_______ Cell#________________________

Parents Marital Status: (single / married / divorced) Who is responsible for making appts? __________________

Who is financially responsible for this account? _________________________________ Relation___________________

Address (if other than patient) ____ Phone# ___________________

INSURANCE INFORMATION: Do you have Orthodontic coverage **Y** / **N** If yes, complete the following:

PRIMARY CARRIER_ _____________________ Address____

Phone#_______________________ Group# _______________________ ID# / SS# ____________________________

Insured's Name____________________________ DOB_________________ Relationship to Patient________________

Employer_________________________________ Phone#___________________________

SECONDARY CARRIER____________________ Address____

Phone#________________________ Group# _______________________ ID# / SS# ____________________________

Insured's Name____________________________ DOB_________________ Relationship to Patient________________

Employer_________________________________ Phone#___________________________

HEALTH HISTORY

Y / N 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 fluoride supplements?

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

Y / N Does the child brush his/her teeth daily? If yes, how often? _____________

Y / N Does the child floss his/her teeth? If yes, how often? _____________

Does the child have any of the following habits?

Y / N Thumb/Finger sucking

Y / N Lip sucking

Y / N Nail biting

Y / N Nursing bottle habits

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

Please describe the child's general health: GOOD / FAIR / POOR

Child's Physician _____________________________ Phone# ______________________

Last Visit ______________________

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

Y / N Heart Murmur

Y / N Congenital Heart Defect

Y / N Cancer

Y / N Convulsions / Epilepsy

Y / N Diabetes

Y / N Abnormal Bleeding

Y / N Asthma / Disabilities

Y / N Rheumatic Fever

Y / N HIV+ / AIDS

Y / N Any Operations

Y / N Hemophilia

Y / N Hearing Impairment

Y / N Any Stays in Hospital

Y / N History of Scarlet Fever

Y / N Kidney / Liver Problems

Y / N Hepatitis

Y / N Handicaps

Y / N Tuberculosis

Y / N Allergies to Any Drugs

Y / N Prosthesis

Please list any medication the child is currently taking:

____

Please list all medication the child is allergic to:

____