Orthodontics for Children and Adults

Date: ____________________

Child's Name: ____ S.S.N ________________________
(Last) (First) (M)

Nickname: ____________________________________ Male: __________ Female: _________

Date of Birth: ________________________ Age: _____ yrs. _____mos. Phone: ________________________
Mo. Day Year

Address: ____, _________________, ____________, ________
Street City State Zip

RESPONSIBLE PARTY INFORMATION

Mr. __ Mrs. __ Ms. __ Miss __ Dr. __ Rev. __ Other _____________

Name: _________________________________ S.S.N: ________________________D.O.B.______________

Home Address: ___________________________________ Home Phone: ______________________________

Employed by: ___________________________________ Occupation: ______________________________

Business Address: ________________________________ Business Phone: ___________________________

Relationship to patient:_________________ Person(s) responsible for account:____________________________

Mr. __ Mrs. __ Ms. __ Miss __ Dr. __ Rev. __ Other _____________

Name: _________________________________ S.S.N: ________________________D.O.B.______________

Home Address: ___________________________________ Home Phone: ______________________________

Employed by: ___________________________________ Occupation: ______________________________

Business Address: ________________________________ Business Phone: ___________________________

Relationship to patient:_________________ Person(s) responsible for account:____________________________

Child's Dentist: Dr.______________________ How were you referred to our office?________________________

Insurance Information (Please list all dental coverage)

Name of Insured: (1) ____________________________ ID# (1) ______________________________

(2) ____________________________ ID# (2) ______________________________

Name of Insurance Co.: (1) ________________________ Ins. Phone # (1) ___________________________

(2) ________________________ Ins. Phone # (2) ___________________________

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Your careful complete answers to the following questions will be very helpful in the evaluation of your child's orthodontic problem.

Physician: ______________________ Address: ______________________
Date of last physical examination: ______________ Results: ______________________
Height: __________ Weight: __________ Is your child in good health?..Yes ( ) No ( )

Does your child have any history of major illness? Yes ( ) No ( ) Explain: ______________________

Check any of the following medical conditions that your child has been treated for:

___ Diabetes	___ High blood pressure	___ Hormone Disorder	___ Sinus Infection	___ Rheumatic Fever
___ Anemia	___ Emotional Problems	___ Bone Disorders	___ Convulsions	___ Joint Replacement
___ Epilepsy	___ Fainting/Dizziness	___ Hepatitis	___ Allergies	___ Heart Trouble
___ Headaches	___ Bleeding Disorders	___ Arthritis	___ Venereal Disease	___ Heart Murmur
___ AIDS/HIV+	___ Ear Infection	___ Cancer	___ Asthma-Hay Fever	___ Congenital Heart Defect

Does your child vomit, gag, or faint easily?..Yes ( ) No ( )
Does your child have a tendency to colds? ____ Sore throats? ____ Ear Infections? ____
Have tonsils and adenoids been removed?..Yes ( ) No ( )
List and allergies or drug sensitivity: ______________________
List any drug or medications being taken. Give reasons: ______________________

DENTAL HISTORY

Why did you bring your child to the orthodontist today? ______________________
Have any teeth been injured due to accidents or falls?..Yes ( ) No ( )
Has the child had any severe head, neck, or facial injuries?..Yes ( ) No ( )
Give details of injuries: ______________________
Have the child ever sucked a thumb or finger?..Yes ( ) No ( )
Does the child have any speech problems?..Yes ( ) No ( )
Is the child a mouth breather?..Yes ( ) No ( )
Does the child experience headaches or pain in or around the ears?..Yes ( ) No ( )
Does the child grind their teeth?..Yes ( ) No ( )
Does the child experience grating or popping noises in the jaw joints?..Yes ( ) No ( )
When did you last have dental care? __________ Next visit: __________
Does the child brush their teeth in the morning? __________ After lunch? __________ Before retiring? __________
Has the child ever had any deciduous (baby) or permanent teeth removed?..Yes ( ) No ( )
Has anyone in the family had orthodontic treatment?..Yes ( ) No ( )
Are you aware that some appointments will infringe on school time? ....Yes ( ) No ( )

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

SIGNATURE ______________________ DATE ______________________
(If patient is a minor, parent or guardian please sign)

Father's E-Mail Address: ______________________

Mother's E-Mail Address: ______________________

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