



Tell Us About Your Child

Today's Date: ___/___/___ Preferred Name: _____

Child's Name _____
LAST FIRST MI

Birthdate: ___/___/___ Age: _____ Male Female

School: _____ Hobbies: _____

Address: _____

CITY STATE ZIP

Home Phone: _____

Cell Phone: _____

Email: _____

General Information

Who is accompanying child today?

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?

Other siblings/ages: _____

Preferred appointment reminder method:

Email _____

Text # _____

Parent's Information

Father Stepfather Guardian

Mother Stepmother Guardian

Marital Status: S M D W Birthdate: ___/___/___

Marital Status: S M D W Birthdate: ___/___/___

Name: _____

Name: _____

Address: (If different than child's)

Address: (If different than child's)

Hm Phone: _____ Cell: _____

Hm Phone: _____ Cell: _____

Work Phone: _____ SSN: _____

Work Phone: _____ SSN: _____

Employer: _____

Employer: _____

Email: _____

Email: _____

Insurance Co. Name: _____

Insurance Co. Name: _____

Insured's ID #: _____ Group #: _____

Insured's ID #: _____ Group #: _____

Ins. Phone: _____

Ins. Phone: _____

(PLEASE COMPLETE BACK OF FORM)



Dental and Medical History

General Dentist: _____ Phone: _____

Address: _____

Last cleaning: ___/___/___ Has patient ever been evaluated for or had orthodontic treatment before: Y / N

Child's Interest in treatment: Excited Willing Reluctant

Does/did the patient have the following habits? Grind teeth Y / N Finger/Thumb sucking Y / N

Have Tonsils Adenoids been removed? No

Has the patient experienced any unfavorable reaction from any previous dental or medical care? Y / N

Does patient require antibiotics before dental procedures? Y / N

If yes, please specify and give reason for this need: _____

Does the patient brush teeth: Often Occasionally Reluctantly

Family Physician: _____ Phone: _____

Address: _____

Is patient currently under a physician's care? Y / N If yes, explain: _____

Is patient taking any medicine at this time? Y / N Please specify: _____

Is patient allergic to any medication? Y / N Please specify: _____

Does patient have any known allergies? Y / N Please specify: _____

Has the patient been hospitalized or had any surgeries?? Y / N Please specify: _____

Does the patient have any history of these (Circle all that apply)?:

- | | | | |
|---|---------------------------------|--------------------------------------|-------------------------------|
| Yes / No Allergies | Yes / No Lung Disorder | Yes / No Heart Disorder/Murmur | Yes / No Speech Difficulties |
| Yes / No Anemia | Yes / No Breathing difficulties | Yes / No Hypertension | Yes / No Emotional Disorders |
| Yes / No Prolonged bleeding/Clotting Disorder | Yes / No Asthma | Yes / No Congenital Heart Disease | Yes / No Hearing difficulties |
| Yes / No Bone Problem or Disorder | Yes / No Bronchitis | Yes / No Rheumatic fever | |
| Yes / No Arthritis/Joint Swelling | Yes / No Tuberculosis | Yes / No Endocrine/Hormone disorders | |
| Yes / No Artificial Joint | Yes / No Neurologic disorder | Yes / No Diabetes | |
| Yes / No AIDS or HIV | Yes / No Cerebral palsy | Yes / No Hepatitis or Liver Disorder | |
| Yes / No ADD/ADHD | Yes / No Convulsions/ Seizures | Yes / No Kidney or bladder Disorder | |

If patient is experiencing or has a history of any disease, condition or problem not addressed, please explain:

Signature: _____ Date: _____

Relationship to patient: _____