CHILD PATIENT INFORMATION

Date ______________________________

Patient's Name ______________________________
LAST FIRST MIDDLE

Residence ______________________________
STREET CITY ZIP

Mailing Address ______________________________
STREET CITY ZIP

Home Phone ______________ Work Phone ______________ Cell Phone ______________
MOTHER/FATHER MOTHER/FATHER

Birth Date ______________ Gender ________ Email ______________
M/F MOTHER/FATHER

Referred By ______________ Family Dentist ______________

Primary Care Physician ______________________________

Parent/Guardian Name ______________ Relationship to Patient ______________

Mailing Address ______________________________
STREET CITY ZIP

Phone ______________ Birth Date ______________ Email ______________

Parent/Guardian Name ______________ Relationship to Patient ______________

Mailing Address ______________________________
STREET CITY ZIP

Phone ______________ Birth Date ______________ Email ______________

Emergency Contact ______________________________

Relationship to Patient ______________ Phone ______________

INSURANCE INFORMATION

Primary Dental Insurance Carrier ______________ Member ID # ______________

Policy Holder Name ______________ Relationship ______________

Date of Birth ______________ Social Security # ______________

Secondary Dental Insurance Carrier ______________ Member ID # ______________

Policy Holder Name ______________ Relationship ______________

Date of Birth ______________ Social Security # ______________

I understand that, where appropriate, credit bureau reports may be obtained.

Signature: ______________________________ Date ______________

Updates (Date & Initial): ______________________________

MEDICAL HISTORY

Please check Yes or No (If Yes, please fill in details)

☐ Yes ☐ No Is the patient good health? ______

☐ Yes ☐ No Does the patient regularly take anti-inflammatory drugs? (Advil, Ibuprofen, Celebrex) ______

☐ Yes ☐ No Onset of puberty? ______ IF YES, DATE

☐ Yes ☐ No Has the patient's tonsils or adenoids been removed? ______

☐ Yes ☐ No Does the patient snore? ______

☐ Yes ☐ No Is the patient a mouth breather? ______

Has the patient been treated for any of the following:

☐ Diabetes	☐ Bone Disorders	☐ Asthma	☐ Nervous Disorders
☐ Pneumonia	☐ Autism	☐ Kidney/Liver Problems	☐ Frequent Colds/Sore Throat
☐ Diabetes	☐ Tuberculosis	☐ Endocrine Problems	
☐ Prolonged Bleeding	☐ Heart Trouble/Murmur	☐ Anemia	☐ Frequent Ear Problems
☐ Rheumatic Fever	☐ Epilepsy	☐ Fainting/Dizziness	

Are there any other medical conditions we have not discussed that you feel we should be aware of? ______

______

DENTAL HISTORY

☐ Yes ☐ No Has the patient ever sucked a thumb or pacifier? ______ IF YES, TILL WHAT AGE?

☐ Yes ☐ No Does the patient have any speech problems? ______ IF YES, EXPLAIN

☐ Yes ☐ No Does the patient have any missing or extra permanent teeth? ______

☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? ______ IF YES, EXPLAIN

☐ Yes ☐ No Has the patient experienced any head or neck pain? ______

☐ Yes ☐ No Has the patient experienced any ear pain? ______

☐ Yes ☐ No Has the patient experienced any clicking, popping, grinding, or locking of the jaw? ______

☐ Yes ☐ No Has the patient experienced frequent headaches? ______

☐ Yes ☐ No Does the patient play any sports? ______ IF YES, WHICH SPORTS?

☐ Yes ☐ No Does the patient play any musical instruments? ______ IF YES, WHICH ONE(S)?

☐ Yes ☐ No Has the patient been consulted by an orthodontist previously? ______ IF YES, WHICH ORTHODONTIST?

In your own words, what do you see as the problem? ______

______

I consent to and all diagnostic procedures and orthodontic treatment provided by the doctor, assistants, or other personnel. I release and information concerning my (my child's) health care, advice, and treatment to another dentist for evaluating and administering treatment. I authorize payment of any dental benefits to this practice for services rendered.

Signature: ______ Date: ______