



ORTHODONTICS  
For Children & Adults

For Children | Welcome to our practice!

17  
Years  
of creating  
great smiles!

### 1 Tell us about your child

Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ AGE: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Mi \_\_\_\_\_

Nickname : \_\_\_\_\_ Sex: \_\_\_\_\_

School : \_\_\_\_\_ Grade: \_\_\_\_\_

Home # : \_\_\_\_\_

SS # : \_\_\_\_\_

#### Child's Home Address:

\_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Siblings: \_\_\_\_\_ 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 # : \_\_\_\_\_

E-mail : \_\_\_\_\_

Employer : \_\_\_\_\_

DL # : \_\_\_\_\_

SS # \_\_\_\_\_

#### Who is responsible for making appts?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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 your child to the orthodontist?**

Why have you come to the orthodontist today? :

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever had a serious/difficult problem associated with dental work? Yes No

Is your child's water fluoridated? Yes No

Is your child taking fluoridated supplements? Yes No

Has your child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Does your child brush teeth daily? Yes No

Floss their teeth daily? Yes No

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Last visit \_\_\_\_\_

Is your child currently under the care of a physician? Yes No

Please describe your child's health:

**GOOD FAIR POOR**

Please list all drugs your child is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Please list all drugs your child is allergic to:

\_\_\_\_\_  
\_\_\_\_\_

**7 Has your child ever had any of the following?**

- |                  |                              |
|------------------|------------------------------|
| 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 your child has had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8 Does your child have any of the following**

- 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.

**facebook** Are you on Facebook? **YES NO**  
*We are too & would love for you to connect with us!*

**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 preform 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 --- 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: \_\_\_\_\_