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Welcome To Our Office.
So that we might become better acquainted, please complete both sides of this form.

Child Patient Information

Patient's Name_____ Preferred Name_____ Sex_____
Home Address_____ City_____ Zip_____
E-mail Address_____Would you like to be reminded of upcoming appt? Y or N
Patient resides with ☐ Mother ☐ Father ☐ Both ☐ Other_____
Home Phone_____Age_____Birthday_____School_____Grade_____
Cell Phone _____ Texting Y or N **Company name of cell phone provider** _____
Patient's Dentist _____ Referred by _____
Any relatives or friends treated here?_____ If so, Whom _____
Please describe your child's orthodontic problem in your own words _____
_____

Parents and Account Information

Marital status of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

	Father	Mother
Name		
Address (if different from above)		
E-mail		
Phone (if different from above)		
Cell Phone		
Social Security Number		
Employer's Name		
Business Address		
Business Phone		
Occupation		
Person Responsible for Account		

If other than parent:
Name_____ Address_____ Phone_____

Dental Insurance Information

Name of Insured (employee) _____ Date of Birth _____
Name of Insurance Company _____ Group # _____

(over)

Medical History

Is your child in good health? ☐ No ☐ Yes Explain _____

Does your child have any history of major illness? ☐ No ☐ Yes Explain _____

Has your child been under the care of a physician for illness? ☐ No ☐ Yes Explain _____

Have tonsils &/or adenoids been removed? ☐ No ☐ Yes If so, at what age? _____

Does your child have frequent colds or ear infection? ☐ No ☐ Yes Explain _____

Is your child currently taking medication? ☐ No ☐ Yes Please list _____

Is your child allergic to any medications? ☐ No ☐ Yes Please list _____

Is your child allergic to Latex? ☐ No ☐ Yes

Please check if your child has any of the following conditions:

Hear Murmur/Heart Disorder	____ No	____ Yes	Epilepsy, Seizure	____ No	____ Yes
Joint or Heart Valve Replacement	____ No	____ Yes	Ear Problems	____ No	____ Yes
Rheumatic Fever	____ No	____ Yes	Throat/Nose Problems	____ No	____ Yes
Prolonged Bleeding	____ No	____ Yes	Tonsillitis	____ No	____ Yes
Abnormal Blood Pressure	____ No	____ Yes	Eye Problems/Glaucoma	____ No	____ Yes
AIDS/HIV Infection	____ No	____ Yes	Hormonal Abnormalities	____ No	____ Yes
Diabetes	____ No	____ Yes	Developmental Disorder	____ No	____ Yes
Asthma/Allergies	____ No	____ Yes	Nervous Disorder	____ No	____ Yes
Hepatitis	____ No	____ Yes	Brain Injury/Stroke	____ No	____ Yes
Tuberculosis	____ No	____ Yes	Emotional Problems	____ No	____ Yes

Are there any other conditions or problems you think we should know about?_____

_____

Dental History

When did your child last visit the dentist? _____

Is there any unfinished care to be completed with your child's dentist? ☐ No ☐ Yes Explain _____

Has your child had any face or dental injuries? ☐ No ☐ Yes Explain _____

Is there any history of thumb or finger sucking? ☐ No ☐ Yes Explain _____

Has your child had any previous orthodontic treatment? ☐ No ☐ Yes Explain _____

Is there any other information that may be helpful? _____

I certify the above information to be true to the best of my knowledge.

_____ _____

Signature Date