FOR CHILDREN: WELCOME TO OUR PRACTICE

1. TELL US ABOUT YOUR CHILD

Today's date: ____________ DOB: ____________

Child's Name: Age: ____________

____
Last First Middle

Preferred Name: ____________ ☐ Male ☐ Female

School: ____________ Grade: ____________

Home#: ____________ Cell#: ____________

Email: ____________ SS#: ____________

Hobbies / Special Interests: ____________

Child's Home Address:

____
Apt#:

____
City State Zip

Siblings:

Name: ____________ Age: ____________

Name: ____________ 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: ____________ Cell#: ____________

WK#: ____________ Home#: ____________

Employer: ____________

SS#: ____________

4. FATHER'S INFORMATION

Name: ____________ Cell#: ____________

WK#: ____________ Home#: ____________

Employer: ____________

SS#: ____________

5. RESPONSIBLE PARTY INFO

Name: ____________

Billing address : ____________

____
City State Zip

WK#: ____________ Home#: ____________

Cell#: ____________

Email: ____________

Employer: ____________

SS#: ____________

6. 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

7. 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

8. DENTAL HISTORY

Why did you bring this child to the Orthodontist today? : ____________________

____

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

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

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

Does the child brush teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

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

Explain: ____________________

Child's Physician: ____________________

Phone #: ____________________ Last Visit: ____________________

Please describe the child's health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs the child is currently taking: ____________________

____

Please list all drugs the child is allergic to: ____________________

9. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drugs
☐	☐	Prosthesis	☐	☐	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

____

10. DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Yes	No		Yes	No	
☐	☐	Thumb sucking / Finger sucking	☐	☐	Nail Biting
☐	☐	Lip sucking / biting	☐	☐	Nursing Bottle Habits

Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11. 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.

Signature of parent/guardian_____________________________________ Date:____________________________

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:____

1. Date:_______________ Signature:___________________

Comments:____