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

Is this child adopted? Y / N

Whom may we thank for referring you?

____

Other siblings/ages: _____________________

____

Preferred appointment reminder method:

□ Email: _______________________________

□ Text #: ______________________________

Parent's Information

□ Father □ Stepfather □ Guardian

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

Name:____

Address: (If different than child's)

____

____

Hm Phone:____________________Cell:____________________

Work Phone:____________________ SSN:__________________

Employer:____

Email:____

Insurance Co. Name:__________________________________

Insured's ID #:____________________ Group #:____________

Ins. Phone:____

□ Mother □ Stepmother □ Guardian

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

Name:____

Address: (If different than child's)

____

____

Hm Phone:____________________Cell:____________________

Work Phone:____________________ SSN:__________________

Employer:____

Email:____

Insurance Co. Name:__________________________________

Insured's ID #:____________________ Group #:____________

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 medications? Y / N Please specify: ____

Does patient have any known allergies (nuts, latex, etc.)? 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?:

Yes / No Seasonal Allergies
Yes / No Anemia
Yes / No Prolonged bleeding/Clotting Disorder
Yes / No Bone Problem or Disorder
Yes / No Arthritis/Joint Swelling
Yes / No Artificial Joint
Yes / No AIDS or HIV
Yes / No ADD/ADHD

Yes / No Lung Disorder
Yes / No Breathing difficulties
Yes / No Asthma
Yes / No Bronchitis
Yes / No Tuberculosis
Yes / No Neurologic disorder
Yes / No Cerebral palsy
Yes / No Convulsions/ Seizures

Yes / No Heart Disorder/Murmur
Yes / No Hypertension
Yes / No Congenital Heart Disease
Yes / No Rheumatic fever
Yes / No Endocrine/Hormone disorders
Yes / No Diabetes
Yes / No Hepatitis or Liver Disorder
Yes / No Kidney or bladder Disorder

Yes / No Speech Difficulties
Yes / No Emotional Disorders
Yes / No Hearing difficulties
Yes / No Autism

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

____

Signature:____ **Date**: ______________________________

Relationship to patient: ____