FOR CHILDREN: *WELCOME TO OUR PRACTICE*

TELL US ABOUT YOUR CHILD

Today's date: ______________ Age: _______ DOB: __________

Name: ____
Last *First* *Middle*

Preferred Name: ________________________________

❒ Male ❒ Female

School: ____________________________ Grade: ________

Home #: __________________ Cell #: __________________

Email: __________________ SSN: __________________

Hobbies/Special Interests: __________________________

____

Child's Home Address:

____

____
City *State* *Zip*

Siblings:

Name: __________________ Age: ______________

Name: __________________ Age: ______________

Name: __________________ Age: ______________

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: ______________________

Address: ____

____
City *State* *Zip*

Phone #: __________________ Last Visit: ______________

Parent's Marital Status: ❒ Single ❒ Married ❒ Divorced

MOTHER'S INFORMATION

Name: ____

Employer: ____

Home #: __________ Cell #: __________ Work #: __________

SSN: ____

FATHER'S INFORMATION

Name: ____

Employer: ____

Home #: __________ Cell #: __________ Work #: __________

SSN: ____

RESPONSIBLE PARTY INFO

Name: ____

Billing address: ________________________________

____
City *State* *Zip*

Work #: ________________ Home #: ________________

Cell #: ________________ Email: ________________

Employer: ____

SSN: ____

PRIMARY DENTAL INSURANCE

Ins. Name: ____

Ins. address: ____

____
City *State* *Zip*

Insurance Co. Phone #:: ____________________________

Group/Policy #: ________________________________

Insured's Name: ________________________________

Relationship to Patient: ____________________________

Insured's DOB: ________________________________

Insured's Employer: ____________________________

SSN: ____

Orthodontic Coverage ❒ Yes ❒ No

SECONDARY DENTAL INSURANCE

Ins. Name: ______________________

Ins. address: ______________________

____

City *State* *Zip*

Insurance Co. Phone #:: ______________________

Group/Policy #: ______________________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured's DOB: ______________________

Insured's Employer: ______________________

SSN: ______________________

Orthodontic Coverage ❐ Yes ❐ No

HEALTH HISTORY

Y	N		Y	N	
❐	❐	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
❐	❐	Other: ______________________			

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

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: ____________

____

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Y	N		Y	N	
❐	❐	Aspirin	❐	❐	Penicillin
❐	❐	Codeine	❐	❐	Erythromycin
❐	❐	Latex	❐	❐	Tetracycline
❐	❐	Other: ______________________			

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y	N		Y	N	
❐	❐	Thumb sucking / Finger sucking	❐	❐	Nail Biting
❐	❐	Lip sucking / biting	❐	❐	Nursing Bottle Habits
❐	❐	Other: ______________________			

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

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: ______________________ **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:

Date: ____________ Signature: ____________

Comments: ______________________

Date: ____________ Signature: ____________

Comments: ______________________