CHILD
PATIENT INFORMATION

Welcome
to our Office!

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We are a team committed to excellence and it is our privilege to help you with your smile. This information is held confidential and will help us to better serve you. Please answer both sides of this form completely.

Getting to know you

Name:	Nickname:		Birthdate:
Home Address:	City:	Zip:	Sex:
Home Phone: ( )	School:		Grade:
Social Security	If patient is a minor, give guardian's name		

What are your goals?

If you could change anything about your child's smile or bite, what would it be? _____
How long have you wanted to have this changed? _____
What factors have been standing in your way? _____
Do you have any other concerns about undergoing orthodontic treatment? _____
Have any other family members had orthodontic treatment? (Please List) _____
Whom may we thank for referring you? _____

Medical History

Is the patient currently seeing a physician or taking any medications? Yes No If yes what for? _____
Is the patient allergic to any medications? (Sulfa, Penicillin, Novocaine) Yes No If yes to what? _____
Does the patient suffer from frequent headaches? Yes No If yes when? _____
Describe any injuries to the face or teeth. _____
Has there been any history of (Circle Y for Yes and N for No):

Joint Swelling	Y N	Heart Trouble	Y N	Asthma	Y N	Tuberculosis	Y N
Artificial Joints	Y N	Allergies to metal	Y N	Psychiatric Treatment	Y N	Rheumatic Fever	Y N
Kidney Ailment	Y N	Liver Ailment	Y N	Epilepsy	Y N	Heart Murmur	Y N
Herpes/oral cold sores	Y N	Blood Disorder	Y N	Speech Problems	Y N	Cancer	Y N
Fainting/Seizures	Y N	Arthritis	Y N	Bone disorders	Y N		
Emotional Problems	Y N	AIDS/HIV	Y N	Hepatitis	Y N		

Are there any medical, dental or surgical problems not covered above? _____
Physician: _____ City: _____ Phone: _____ Last Exam Date: _____

Dental History

How often does patient brush his/her teeth each day? ❑ Several times ❑ Twice ❑ Once ❑ Less than once
Any Habits? (check all that apply) ❑ Lip biting ❑ Nailbiting ❑ Thumbsucking ❑ Other
Has the patient ever experienced: ❑ Headaches ❑ Ear Aches ❑ Jaw Clicking/Popping ❑ Jaw Pain
Has the patient ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
If any teeth have been removed (extracted), which? _____
Has the patient ever been treated for : ❑ Bad Breath ❑ TMJ ❑ Periodontal Disease
Has an orthodontists been consulted previously? ❑ Yes ❑ No Whom/When? _____
If yes, what was it that caused you to seek a second opinion? _____
Growth Status:Girls-When was your first menstrual period? ❑ Not yet ❑ Less than a year ago ❑ More than a year ago
Boys - Is your voice changing? ❑ Yes ❑ No How often do you shave? ❑ Not yet ❑ Weekly ❑ Daily
Has the patient shown signs of increased growth recently? ❑ Yes ❑ No
Patient's Height _____ Father's Height _____ Mother's Height _____
Dentist: _____ City: _____ Phone: _____ Last Exam: _____

Over Please

Confidential Responsible Party Information

Name _____ Marital Status _____
Residence _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
How long at this address _____ Phone #'s: Home _____ Work _____ Cell _____
Previous Address *(if less than 3 years)* _____ City _____ State _____ Zip _____
Social Security # _____ Birthdate _____ / _____ / _____ Relationship to patient _____
Employer _____ Occupation _____ # years employed _____
Spouse's Name _____ Relationship to patient _____
Employer _____ Occupation _____ # years employed _____
Social Security # _____ Birthdate _____ / _____ / _____ Work phone _____

Insurance Information

Policy Holder's Name _____ Social Security # _____
Insurance Company _____ Group # _____ ID# _____
Insurance Company's Phone _____
Policy Holder's Employer _____
Do you have dual coverage? ❑ YES ❑ NO If yes, complete the following information...
Policy Holder's name _____ Social Security # _____
Insurance Company _____ Group # _____ ID# _____
Insurance Company's Phone _____
Policy Holder's Employer _____

Emergency Information

Name of nearest relative NOT living with you _____
Complete Address _____ City _____ State _____ Zip _____
Phone #'s: Home _____ Work _____ Cell _____
Relationship to you _____

Signature

I understand that where appropriate, credit bureau reports may be obtained.
Signature *(guardian's signature if patient is a minor)* _____
Updates *(date and initial)* _____

CONFIDENTIAL *(for record and pretreatment evaluation)*