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Child Patient Information

Patient's Name _____ Today's Date _____

Mailing Address _____ City _____ State _____ Zip _____

Birth Date ____/____/____ Age ____ M F Grade _____ School _____

Dentist _____ Date of Last Dental Check Up _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Father's Name _____ Single Married Divorced Separated

Address _____ City _____ State _____ Zip _____ Yrs _____

Home Phone _____ Work Phone _____ Cell Phone _____

Family Email Address : _____

Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Mother's Name _____ Single Married Divorced Separated

Address _____ City _____ State _____ Zip _____ Yrs _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co Address _____ City _____ State _____ Zip _____

Phone _____

2nd Insured's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co Address _____ City _____ State _____ Zip _____

Phone _____

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.

Emergency Contact Information

Name of nearest relative *not* living with you _____ Phone _____

Please continue to the back

Dental History

What is your chief concern? _____

Are you interested in: (please indicate all that apply)

Information Treatment now Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? Yes No
2. Does the patient have any speech problems? Yes No
3. Has the patient ever been informed of any missing or extra permanent teeth? Yes No
4. Has any previous orthodontic treatment been rendered? Yes No
5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.? Yes No
6. Have you ever observed your child has any habits? Thumb/finger sucking Mouth breathing Tongue thrust

Other: _____

Medical History

Name of your physician _____ Date of last exam _____

1. Is the patient in good health? Yes No
2. Does the patient have a health problem? Yes No If yes, explain _____
3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc.)?
 Yes No If yes, please list: _____
4. Please list any current prescription medications: _____
5. Has the patient had any recent rapid growth Yes No Early? Late? Females: Has menstruation begun? Yes No
If yes, when? _____ Pregnant? Yes No
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

<input type="checkbox"/> Problems at Birth	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Disease/Murmur	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Cleft Lip/Palate
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Speech or Hearing Problems
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Cancer/Radiation Therapy	<input type="checkbox"/> Tonsil, Adenoid, Sinus Problems
<input type="checkbox"/> Anemia/Hemophilia	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Emotional/Behavior Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Asthma	<input type="checkbox"/> Growth Problems

Other: _____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any *changes*. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

Responsible party signature

Date