

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	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Def.
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment
<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Any Operations
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Any Stays in Hospital
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Any Drugs
<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking / Finger sucking	<input type="checkbox"/>	<input type="checkbox"/>	Nail Biting
<input type="checkbox"/>	<input type="checkbox"/>	Lip sucking / biting	<input type="checkbox"/>	<input type="checkbox"/>	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: _____