

FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD			
Today's date: _____		DOB: _____	
Child's Name:		AGE: _____	
Last _____	First _____	Mi _____	
Nickname: _____		<input type="checkbox"/> Male	<input type="checkbox"/> Female
School: _____		Grade: _____	
Home #: _____			
SS #: _____			
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: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____
FATHER'S INFORMATION:
Name: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____

4.) RESPONSIBLE PARTY INFO:
Name: _____
Billing address: _____
City _____ State _____ Zip _____
WK#: _____ Ext. _____ HM#: _____
Cell #: _____
Email: _____
Employer: _____
DL#: _____
SS#: _____
Who is responsible for making appts?
Name: _____
WK#: _____ Ext. _____ HM#: _____

5.) 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
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

6) Why did you bring the child to the Orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work? Y N
 Is the child's water fluoridated? Y N
 Is the child taking fluoridated supplements? Y N

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

Y N
 Does the child brush teeth daily? Y N
 Floss their teeth daily? Y N

Child's Physician: _____
 Phone#: _____ Last visit: _____

Is the child currently under the care of a physician? Y N

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: _____

7) Has the child ever had any of the following medical problems?

- | | |
|------------------|------------------------------|
| Y N Heart Murm. | Y N Congenital Heart Def. |
| Y N Cancer | Y N Convulsions/Epilepsy |
| Y N Diabetes | Y N Abnormal Bleeding |
| Y N Rheum. Fev. | Y N Hearing Impairment |
| Y N HIV+/AIDS | Y N Any Operations |
| Y N Hemophilia | Y N Any Stays in Hospital |
| Y N Asthma | Y N Kidney/Liver Problems |
| Y N Hepatitis | Y N Handicaps/Disabilities |
| Y N Tuberculosis | Y N Allergies to Any Drugs |
| Y N Prosthesis | Y N History of Scarlet Fever |

Please discuss any serious medical problems that the child has had: _____

8) Does the child have any of the following habits?

- Y N Thumb sucking / Finger sucking
 Y N Lip sucking / biting
 Y N Nail Biting
 Y N Nursing Bottle Habits

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

9) 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. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent/guardian _____ Date _____

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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: _____

2. Date: _____ Signature: _____
 Comments: _____