

FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD		
Today's date: _____	DOB: _____	
Child's Name: _____	AGE: _____	

Last _____	First _____	Mi _____
Nickname: _____	Male Female	
School: _____	Grade: _____	
Home #: _____	_____	
SS #:	_____	
Child's Home Address:		
_____		Apt# _____
_____	City _____	State _____ Zip _____
Siblings:		
Name _____	Age _____	
Name _____	Age _____	

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#: _____

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)

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 _____

3.) MOTHER'S INFORMATION
Name: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____
FATHER'S INFORMATION
Name: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____

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: _____