



Today's Date: \_\_\_/\_\_\_/\_\_\_ Preferred Name: \_\_\_\_\_

### Tell Us About Your Child

Child's Name \_\_\_\_\_  
LAST FIRST MI

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  Male  Female

School: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Parent's Information

Father  Stepfather  Guardian  Mother  Stepmother  Guardian

Marital Status: S M D W Birthdate: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Address: (If different than child's)

Hm Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Email: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_

### General Information

Who is accompanying child today?  
\_\_\_\_\_

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?  
\_\_\_\_\_

Other siblings/ages: \_\_\_\_\_

Preferred appointment reminder method:

Email \_\_\_\_\_

Text # \_\_\_\_\_



# Dental and Medical History

General Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Last cleaning: \_\_\_/\_\_\_/\_\_\_ Has patient ever been evaluated for or had orthodontic treatment before: Y / N

Child's Interest in treatment:  Excited  Willing  Reluctant

Does/did the patient have the following habits? Grind teeth Y / N Finger/Thumb sucking Y / N

Have  Tonsils  Adenoids been removed?  No

Has the patient experienced any unfavorable reaction from any previous dental or medical care? Y / N

Does patient require antibiotics before dental procedures? Y / N

If yes, please specify and give reason for this need: \_\_\_\_\_

Does the patient brush teeth:  Often  Occasionally  Reluctantly

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Is patient currently under a physician's care? Y / N If yes, explain: \_\_\_\_\_

Is patient taking any medicine at this time? Y / N Please specify: \_\_\_\_\_

Is patient allergic to any medications? Y / N Please specify: \_\_\_\_\_

Does patient have any known allergies (nuts, latex, etc.)? Y / N Please specify: \_\_\_\_\_

Has the patient been hospitalized or had any surgeries?? Y / N Please specify: \_\_\_\_\_

Does the patient have any history of these ?:

- |   |                                 |                                      |                               |
|---|---------------------------------|--------------------------------------|-------------------------------|
| Yes / No Seasonal Allergies                   | Yes / No Lung Disorder          | Yes / No Heart Disorder/Murmur       | Yes / No Speech Difficulties  |
| Yes / No Anemia                               | Yes / No Breathing difficulties | Yes / No Hypertension                | Yes / No Emotional Disorders  |
| Yes / No Prolonged bleeding/Clotting Disorder | Yes / No Asthma                 | Yes / No Congenital Heart Disease    | Yes / No Hearing difficulties |
| Yes / No Bone Problem or Disorder             | Yes / No Bronchitis             | Yes / No Rheumatic fever             |                               |
| Yes / No Arthritis/Joint Swelling             | Yes / No Tuberculosis           | Yes / No Endocrine/Hormone disorders |                               |
| Yes / No Artificial Joint                     | Yes / No Neurologic disorder    | Yes / No Diabetes                    |                               |
| Yes / No AIDS or HIV                          | Yes / No Cerebral palsy         | Yes / No Hepatitis or Liver Disorder |                               |
| Yes / No ADD/ADHD                             | Yes / No Convulsions/ Seizures  | Yes / No Kidney or bladder Disorder  |                               |

If patient is experiencing or has a history of any disease, condition or problem not addressed, please explain:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_