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 _____

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:_____