WELCOME TO THE ORTHODONTIST

Today's Date _____
Child's Name:_____
Nickname:_____ ☐ Male ☐ Female
Child's Birthdate:_____ Age:____
School:_____
Hobbies/Sports: _____
Child's Home #:_____
Cell Phone#:_____
Child's Home Address:_____

Who is accompanying your child today?_____
Name: _____ Relation:_____
Do you have legal custody? ☐ Y ☐ N
Whom may we thank for referring you? _____
List brothers/sisters and age: _____
Patient's Dentist_____ Phone # _____
Last Visit Date: _____

Mother's Information/Guardian
Name: _____ Birthdate:_____
Employer: _____
Work #: _____ Ext:_____ Home #:_____
Social Security #:____- ____ -____

Father's Information/Guardian
Name:_____ Birthdate:_____
Employer: _____
Work #: _____ Ext:_____ Home #:_____
Social Security #:____- ____ - ____

Please Turn Over

What are the main concerns that you would like orthodontics to accomplish?

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No
Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No
List any musical instruments played _____
Have adenoids or tonsils been removed? ☐ Yes ☐ No
Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Does your child brush his/her teeth daily? ☐ Yes ☐ No
Child's Physician _____ Date of Last Visit _____
Is your child currently under the care of a physician? ☐ Yes ☐ No
Has puberty begun? ☐ Yes ☐ No
Has menstruation begun? (Girls) ☐ Yes ☐ No
Please describe your child's current health ☐ Good ☐ Fair ☐ Poor
Please list all drugs that your child is currently taking _____
Please list all drugs that your child is allergic to _____
Growth Hormone ☐ Yes ☐ No

Has your child ever had any of the following problems?

Allergies to any Drugs	☐ Yes	☐ No	Allergic to Latex/Metals	☐ Yes	☐ No
Allergic to Plastics	☐ Yes	☐ No	Any Hospital Stays	☐ Yes	☐ No
Any Operations	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	HIV+/AIDs	☐ Yes	☐ No
Kidney/Liver problems	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No

Please discuss any medical problems that your child has _____

_____

Does your child have any of the following habits?

Clenching/Grinding Teeth	☐ Yes	☐ No	Lip Sucking/Biting	☐ Yes	☐ No
Mouth Breather	☐ Yes	☐ No	Nursing Bottle Habits	☐ Yes	☐ No
Nail Biting	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Thumb/Finger Sucking Habits	☐ Yes	☐ No	Tongue Thrust	☐ Yes	☐ No

I understand that the information that I have given is correct to the best of my to knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any change. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date _____

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Kids Are Great Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Kids Are Great Dental's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Kids Are Great Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Kids Are Great Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Kids Are Great Dental already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

Dental Team: Give a copy of this signed form to the patient. Save the original in the patient's file.