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#: _____Email:_____
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: ___/___/___

Parent 1 Information ___ Guardian
Name: _____ Birthdate: ___/___/___
Employer: _____
Work #: _____ Ext: _____ Home #: _____
Social Security #: ____ - ____- ____ Insurance carrier _____

Parent 2 Information ___ Guardian
Name: _____ Birthdate: ___/___/___
Employer: _____
Work #: _____ Ext: _____ Home # _____
Social Security #: ____ - ____ - ____ Insurance carrier_____

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before?__Y__N
Have there been any injuries to the face, mouth, teeth or chin?___Y___N
List any musical instruments played_____
Have adenoids or tonsils been removed?___Y___N
Has your child been informed of any missing or extra permanent teeth?___Y___N
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?___Y___N
Does your child brush his/her teeth daily?___Y___N
Child's Physician _____Date of Last Visit ___/___/___
Is your child currently under the care of a physician?___Y___N
Has puberty begun?___Y___N
Has menstruation begun? (Girls)___Y___N
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 _____Y _____No

Has your child ever had any of the following problems?

Allergies to any Drugs___Y___N
Allergic to Latex/Metals__Y__N
Allergic to Plastics__Y___N
Any Hospital Stays__Y__N
Any Operations__Y__N
Asthma___Y___N
Cancer___Y___N
Congenital Heart Defect__Y___N
Convulsions/Epilepsy__Y__N
Diabetes__Y__N
Handicaps/Disabilities__Y__N
Hearing Impairment___Y___N
Heart Murmur__Y__N
Hemophilia__Y__N
Hepatitis__Y__N
HIV + / Aids__Y__N
Kidney/Liver problems__Y__N
Rheumatic/Scarlet Fever__Y__N
Tuberculosis__Y__N
Abnormal Bleeding__Y__N
Please discuss any medical problems that your child has_____

Does your child have any of the following habits?

Clenching/Grinding Teeth__Y__N
Lip Sucking/Biting__Y__N
Mouth Breather__Y__N
Nursing Bottle Habits__Y__N
Nail Biting__Y__N
Speech Problems__Y__N
Thumb/Finger Sucking Habits__Y__N
Tongue Thrust__Y__N

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_____