

CHILD FORM

Please take this time to tell us about yourself

Today's Date: May 17, 2011

Child's Name: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Child's Home Phone #: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Nickname: \_\_\_\_\_  Male  Female  
 SS# \_\_\_\_\_  
 School attended: \_\_\_\_\_ Grade \_\_\_\_\_

Responsible Party E mail Address: \_\_\_\_\_

Who may we thank for referring you to our office?  
 \_\_\_\_\_

INSURANCE

PRIMARY DENTAL INSURANCE

Orthodontic Coverage?  Yes  No  
 Lifetime Maximum Amount? \_\_\_\_\_  
 Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Insurance Co. Phone: \_\_\_\_\_  
 ID #: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Insured's Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_

SECONDARY DENTAL INSURANCE

Orthodontic Coverage?  Yes  No  
 Lifetime Maximum Amount? \_\_\_\_\_  
 Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Insurance Co. Phone: \_\_\_\_\_  
 ID #: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Insured's Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_

WHO'S ACCOMPANYING CHILD TODAY

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Do you have legal custody of this child?  Yes  No  
 Siblings Name, Age and Birthday: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Parental Marital Status:  
 Single  Married  Divorced  Widowed  Separated

PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_

Who is responsible for making appointments?  
 Mother  Father  Guardian  Other

MOTHER'S INFO:  Step-mother  Guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address (if different from child's): \_\_\_\_\_  
 \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_

FATHER'S INFO:  Step-father  Guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address (if different from child's): \_\_\_\_\_  
 \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_

DENTIST INFORMATION

Dentist Name: \_\_\_\_\_  
 Dentist Phone #: \_\_\_\_\_  
 Last Dental Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MEDICAL HISTORY

Child's Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is he/she taking any prescription medication?  Yes  No

If so, which ones? \_\_\_\_\_

For Girls: Are you pregnant?  Yes  No  
 Has menstruation begun?  Yes  No

Has he/she ever had any of the following diseases or medical problems?

- |                            |  |                 |  |
|----------------------------|--|-----------------|--|
| Abnormal bleeding          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocrine       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV / Aids                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone Disorders             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney problems            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nervous Disorders          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neural Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Serious injury             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nasal/Sinus     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tumor or Cancer            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type of Cancer: | _____  |
| Ear/Throat issues          | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |
| Congenital Heart Defect    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |
| Hepatitis/Liver problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |
| High Blood Pressure        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |
| Radiation/Chemotherapy     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year:           | _____  |
| Asthma or Hay fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |
| Gastrointestinal Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

Does he/she normally require antibiotic pre-medication prior to dental procedures?  Yes  No

Is he/she allergic to any of the following?

- |  |         |  |              |
|--|---------|--|--------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Erythromycin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nickel       |

Please list all other allergies: \_\_\_\_\_

DENTAL HISTORY

Chief complaint/ reason for visit today:

Does your child brush daily?  Yes  No

Injury to the teeth/ jaws?  Yes  No

Removal of tonsils/ adenoids?  Yes  No

History of the following (Circle all that apply)

- |                     |                      |
|---------------------|----------------------|
| Nail biting         | Finger/Thumb Sucking |
| Joint clicking      | Mouth breathing      |
| Grinding            | Speech Problems      |
| Snoring             | Clenching            |
| Joint Pain          | Tongue Thrust        |
| Gum disease         | Headaches/earaches   |
| Jaw growth disorder | Missing teeth        |

Previous orthodontic treatment? When? \_\_\_\_\_

EXPLAIN:

I hereby certify that I have reviewed the above medical and dental history and agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes. I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment.

\_\_\_\_\_ Date \_\_\_\_\_  
 Responsible Party Signature

\_\_\_\_\_ Date \_\_\_\_\_  
 Doctor Signature