

PATIENT INFORMATION – CHILD

ALL ABOUT YOUR CHILD

Name: _____
 Last First MI
 Nickname: _____
 Male: ___ Female: ___ Birthdate: ___/___/___ Age: ___
 School: _____ Grade: _____
 Hobbies/Sports: _____
 Child's Home #: () _____
 Child's Home Address: _____
 City: _____ State: _____ Zip: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____
 Parent's Marital Status: _____
 Do you have legal custody of this child?: _____
 Whom may we thank for referring you?: _____
 Other family members seen by us: _____

DENTIST

General Dentist: _____
 Date of Last Exam: _____

MOTHER STEP MOTHER GUARDIAN

Name: _____
 Last First
 Employer: _____
 Work #: () _____ Ext. _____
 Home #: () _____
 Cell #: () _____
 How long at current job?: _____ Title: _____
 Email: _____
 Do you have dental insurance with orthodontic coverage?: _____

FATHER STEP FATHER GUARDIAN

Name: _____
 Last First
 Employer: _____
 Work #: () _____ Ext. _____
 Home #: () _____
 Cell #: () _____
 How long at current job?: _____ Title: _____
 Email: _____
 Do you have dental insurance with orthodontic coverage?: _____

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

Has your child ever had or been evaluated for orthodontic treatment? YES NO
 Have there been any injuries to the face, mouth, teeth or chin? YES NO
 Has your child ever been informed of any missing or extra permanent teeth? YES NO
 Does your child brush his/her teeth daily? YES NO
 Floss his/her teeth daily? YES NO
 Has puberty begun? YES NO
 Has menstruation begun? (Girls) YES NO
 Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? YES NO

Child's Physician: _____
 Phone #: _____
 Is your child currently under the care of a physician?: _____
 Please list all medications your child is currently taking: _____
 Please list all medications/things your child is allergic to: _____

Has your child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Allergies to any drugs
Y N	Allergic to Latex/Metals	Y N	Allergies to Plastic
Y N	Asthma	Y N	Cancer
Y N	Congenital Heart Defects	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	Hospitalization
Y N	Kidney/Liver Problems	Y N	Operations
Y N	Rheumatic/Scarlet Fever	Y N	Tuberculosis

Please list any medical problems that your child has had: _____

Has your child ever had any of the following habits?

Y N	Clenching/Grinding	Y N	Lip Sucking/Biting
Y N	Nail Biting	Y N	Tongue Thrusting
Y N	Mouth Breathing	Y N	Thumb/Finger Sucking
Y N	Soda Pop Drinker		

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment with my informed consent. Including obtaining x-rays and photographs.

Signature of parent or guardian _____ Date _____
 Reviewed _____ Date _____

