FOR CHILDREN: WELCOME TO OUR PRACTICE

1. TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____

Child's Name: _____ Age: _____

Last First Middle

Preferred Name: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Home#: _____ Cell#: _____

Email: _____ SS#: _____

Hobbies / Special Interests: _____

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: _____ Cell#: _____

WK#: _____ Home#: _____

Employer: _____

SS#: _____

4. FATHER'S INFORMATION

Name: _____ Cell#: _____

WK#: _____ Home#: _____

Employer: _____

SS#: _____

5. RESPONSIBLE PARTY INFO

Name: _____

Billing address : _____

City State Zip

WK#: _____ Home#: _____

Cell#: _____

Email: _____

Employer: _____

SS#: _____

6. 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

7. 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

8. DENTAL HISTORY

Why did you bring this child to the Orthodontist today? : _____

_____

Has the child ever had a serious/difficult problem associated with dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

Explain: _____

Child's Physician: _____

Phone #: _____ Last Visit: _____

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: _____

9. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drugs
☐	☐	Prosthesis	☐	☐	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

10. DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Yes	No		Yes	No	
☐	☐	Thumb sucking / Finger sucking	☐	☐	Nail Biting
☐	☐	Lip sucking / biting	☐	☐	Nursing Bottle Habits

Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11. 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.

Signature of parent/guardian_____ Date:_____

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:_____

1. Date:_____ Signature:_____

Comments:_____