



Welcome!

1. TELL US ABOUT YOUR CHILD

DATE _____

Name _____ I prefer to be called _____

Gender/Sex _____ Gender/Sex at Birth _____

Email address _____ Birth date _____ Social Security# _____

Home Address _____

City _____ State _____ Zip _____ Home # _____

School _____ Grade _____ Hobbies _____

2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name _____ Relation _____ Do you have legal custody of this child? Yes No

Please list brothers / sisters with ages? _____

Who may we thank for referring you? _____ General Dentist: _____ Date of last visit: _____

Parents Marital Status: Single Married Divorced Partnered Separated Widowed

3. PARENTS INFORMATION

Guardian 1

Name _____ Birth Date _____ Social Security# _____

Employer _____ How long at current job? _____ Occupation _____

Work phone# _____ Home phone# _____

Guardian

Name _____ Birth Date _____ Social Security# _____

Employer _____ How long at current job? _____ Occupation _____

Work phone# _____ Home phone# _____

4. INSURANCE INFORMATION

Primary

Insured's Name _____ Insured's SS# _____

Insurance Company _____ Group # _____ Phone _____

Insured's Employer _____ Insured's Date of Birth _____

Address of Insured _____ City _____ State _____ Zip _____

Secondary

Insured's Name _____ Insured's SS# _____

Insurance Company _____ Group # _____ Phone _____

Insured's Employer _____ Insured's Date of Birth _____



5. MEDICAL HISTORY

What treatment goals would you like to accomplish? _____

Has your child ever been evaluated by an orthodontist? Yes No

Has your child ever experienced TMJ pain? Yes No

Has your child been informed of missing or extra permanent teeth? Yes No

Has your child ever taken Phen-Fen? Yes No

Has your child ever taken Fosomax or any other bisphosphonate? Yes No

Have adenoids or tonsils been removed? Yes No

Has your child ever injured his/her mouth, chin or teeth? Yes No

Does your child brush his/her teeth daily? Yes No

Does your child floss his/her teeth daily? Yes No

Is your child currently under the care of a physician? Yes No Please explain: _____

Physician's Name _____ Phone #: _____ Date of Last Visit: _____

Is your child currently taking any medication? Please list each one: _____

Is your child allergic to: Latex Plastics / Metals Aspirin Penicillin ? Other _____

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

Y N Abnormal Bleeding	Y N Asthma	Y N Hemophilia
Y N ADD / ADHD	Y N Cancer	Y N Hepatitis
Y N Allergies to any Drugs	Y N Congenital Heart Defect	Y N HIV+ / AIDS
Y N Allergies to Latex / Metals	Y N Convulsions / Epilepsy	Y N Kidney / Liver Disease
Y N Allergies to Plastic	Y N Diabetes	Y N Rheumatic / Scarlet Fever
Y N Any Hospital Stays	Y N Handicaps / Disabilities	Y N Sinus Problems / Difficulty Breathing
Y N Any Operations	Y N Hearing Impairments	Y N Tuberculosis (TB)
Y N Artificial Bones / Joints / Valves	Y N Heart Murmur	Y N TMJ

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

6. HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS?

Y N Clenching / Grinding Teeth	Y N Nail Biting	Y N Finger / Thumb Sucking
Y N Lip Sucking / Biting	Y N Nursing Bottle Habit	Y N Tongue Thrusting
Y N Mouth Breathing	Y N Speech Problems	

I understand that the information given is correct to the best of my knowledge. I also understand that where appropriate, a credit report may be obtained.

Signature _____ Date _____