

# WELCOME

*We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information - Child or Teen

Patient's Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Nickname (if preferred) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Patient's Home Phone \_\_\_\_\_  
Patient's Home Address Street \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Who is filling in this form? Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Relationship \_\_\_\_\_ Do you have legal custody? YES \_\_\_\_\_ NO \_\_\_\_\_  
Patient's General Dentist \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
Have we treated another member of your family? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_  
Has your child visited an orthodontist before? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, for what reason? \_\_\_\_\_  
Anything you would like to discuss with the doctor in private? YES \_\_\_\_\_ NO \_\_\_\_\_

## Parents Information

Marital Status Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Domestic Partner \_\_\_\_\_

### Father

Father \_\_\_\_\_ Step Father \_\_\_\_\_ Guardian \_\_\_\_\_ Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_  
If you have insurance coverage for the child, please fill out.  
Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

### Mother

Mother \_\_\_\_\_ Step Mother \_\_\_\_\_ Guardian \_\_\_\_\_ Name First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_  
If you have insurance coverage for the child, please fill out.  
Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

## Dental and Medical History

Is the child currently under the care of a physician? YES NO If YES, for what reason? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

History of major illness? YES NO If YES, please describe \_\_\_\_\_

Any sensitivities or allergies? YES NO If YES, please list \_\_\_\_\_

Currently taking any medications? YES NO If YES, please list \_\_\_\_\_ Amount/Dose \_\_\_\_\_

Has Puberty Begun? YES NO

Has menstruation (period) begun? YES NO NOT APPLICABLE

Has the child been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	

Does the child require antibiotics before dental treatment? YES NO If YES, explain \_\_\_\_\_

Have the adenoids or tonsils been removed? YES NO

Have you been informed of any missing or extra permanent teeth? YES NO

Have there been injuries to the child's face, mouth or chin? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO

Does/Did the child have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Prolonged Bottle/Pacifier
Mouth Breather	Speech Problems	Chewing/Eating Problems

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

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