

# Patient Information – Child or Teen

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

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Prefers To Be Called: \_\_\_\_\_

Sex: Male  Female

Address: \_\_\_\_\_

City, St, & Zip: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

Sports And/Or Hobbies: \_\_\_\_\_

Musical Instruments Played: \_\_\_\_\_

Patient's Dentist: \_\_\_\_\_

City: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who suggested that your child might need orthodontic treatment? \_\_\_\_\_

What is your primary concern? \_\_\_\_\_

Other family members treated here: \_\_\_\_\_

Parents Marital Status:  Single  Married  Divorced  Widowed (If divorced) Child resides with: \_\_\_\_\_

	<u>FATHER</u>	<u>MOTHER</u>	<u>GUARDIAN</u>
<b>Name:</b>			
<b>Birth Date:</b>			
<b>Address:</b>			
<b>City, St &amp; Zip:</b>			
<b>Home Phone #:</b>			
<b>Work Phone #:</b>			
<b>Cell Phone #:</b>			
<b>Email Address:</b>			

**Please complete the financial/insurance information on the back**

# Financial/Insurance Information

Who Is Financially Responsible For This Account?

Name: \_\_\_\_\_

Primary Policy Holder's Name: \_\_\_\_\_

Employed By: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, St, & Zip: \_\_\_\_\_

S.S.N.: \_\_\_\_\_

Insurance Coverage For Orthodontic Treatment? Yes  No

Group No. \_\_\_\_\_

Insurance Identification #: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Secondary Policy Holder's Name: \_\_\_\_\_

Employed By: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, St, & Zip: \_\_\_\_\_

S.S.N.: \_\_\_\_\_

Insurance Coverage For Orthodontic Treatment? Yes  No

Group No. \_\_\_\_\_

Insurance Identification #: \_\_\_\_\_

Phone No.: \_\_\_\_\_

# Medical History – Child or Teen

Patient's Name: \_\_\_\_\_

Is patient in good health?  No  Yes Explain: \_\_\_\_\_  
Currently under physician's care?  No  Yes Explain: \_\_\_\_\_  
Tonsils or adenoids been removed?  No  Yes Age: \_\_\_\_\_  
Drug sensitivities?  No  Yes List: \_\_\_\_\_  
Currently taking medications?  No  Yes List (dose): \_\_\_\_\_  
Require antibiotics before dental treatment?  No  Yes List (dose): \_\_\_\_\_  
Allergies?

Ibuprofen  Latex  Antibiotics  Acrylic  Metals  
 Other substance List: \_\_\_\_\_

Please check if there is a history of:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Cardiovascular problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Developmental Disorder
<input type="checkbox"/> Growth Disorders	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Endocrine Disorders
<input type="checkbox"/> Hereditary Problems	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes (fever blisters)
<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Hives/Rash

Are there any other medical conditions that we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

## GROWTH

Has your son or daughter reached puberty?  
Girls – started menstruation? Boys – voice changed?  No  Yes When? \_\_\_\_\_  
Height \_\_\_\_\_ Do you feel growth is complete?  No  Yes

## DENTAL HISTORY

Unfinished dental care?  No  Yes Explain: \_\_\_\_\_  
Frightened about dental treatment?  No  Yes Explain: \_\_\_\_\_  
Any facial or dental injuries?  No  Yes Explain: \_\_\_\_\_  
History of thumb or finger sucking?  No  Yes Explain: \_\_\_\_\_  
Have any teeth been removed?  No  Yes Explain: \_\_\_\_\_  
Any Previous orthodontic treatment?  No  Yes Explain: \_\_\_\_\_  
Consulted an orthodontist previously?  No  Yes Explain: \_\_\_\_\_  
Any family member have treatment?  No  Yes Explain: \_\_\_\_\_

Please check here if there is a history of:

<input type="checkbox"/> Clenching teeth	<input type="checkbox"/> Muscular soreness	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Jaw joint popping	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Headaches (more than normal)
<input type="checkbox"/> Jaw joint clicking	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Snoring
<input type="checkbox"/> Jaw joint soreness	<input type="checkbox"/> Mouth Breathing	
	<input type="checkbox"/> Awake <input type="checkbox"/> Asleep	

## Thank You

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Parent or Guardian)

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Dental Staff Member)