GUYMON
ORTHODONTICS

Child Patient Information:

Date:_____ School and Grade (if applicable): _____

Patient's Name: _____ ☐ Male ☐ Female Prefers to be called: _____

Sports, hobbies, or special interests:_____ Birthdate: _____

Please provide e-mail address (so that we may e-mail appointment dates & times to you):_____

Dentist Name: _____ Date of Last Cleaning: _____

Whom may we thank for referring you to our office?_____

Are other family members treated here?_____ If so, who?_____

Name and ages of siblings_____

Responsible Party/ Insurance Policy Holder Information:

Primary Responsible Party's Name:_____ Marital Status: _____

Address:_____ Cell Phone:_____

City, State, Zip:_____ **Cell Phone Provider** (ex: Sprint, Verizon, ect.)**:**_____

Social Security#:_____ **Birthdate:** _____ Relationship to Patient:_____

Employer:_____ Work Phone: _____

Second Responsible Party's Name: _____ Marital Status: _____

Address: _____ Cell Phone:_____

City, State, Zip: _____ **Cell Phone Provider** (ex: Sprint, Verizon, ect.)**:** _____

Social Security#:_____ **Birthdate:** _____ Relationship to Patient:_____

Employer: _____ Work Phone: _____

Dental Insurance Information:

Insured's Name: _____ Insurance Company: _____

ID#: _____ Group#: _____ Insurance Co. Phone#: _____

Do you have dual coverage? Yes ☐ No ☐ ****If yes, please complete the following:**

Insured's Name: _____Insurance Company: _____

ID#: _____ Group#: _____ Insurance Co. Phone#: _____

Please continue on the back…

Health History:

Is patient taking any medications? _____

Is patient aware of being allergic to or has ever reacted adversely to any medications? _____

Please check the box if you now have or have ever had:	Please check the box if the answer is **YES**:
☐ Latex Allergy	☐ Is the patient pregnant?
☐ Tonsils or Adenoids Removed	☐ Has the patient reached puberty?
☐ Allergies/ Sinus Trouble	☐ Thumb, finger, or lip sucking? (Please circle all that apply)
☐ Artificial Heart Valves	☐ Mouth-breathing when awake or asleep? (Please circle all that apply)
☐ HIV Positive/ AIDS	☐ Any injuries to the face, mouth, or teeth? (Please circle all that apply)
☐ TMJ Problems	☐ Any pain or popping when opening mouth?
☐ Osteoporosis	☐ Are you aware of an uncomfortable or bad bite?
☐ Emotional problems/ Psychiatric treatment	☐ Do you take any bisphosphate medication for osteoporosis?
	☐ Any missing or extra permanent teeth?

Are you aware of any other disease, condition, or problem not listed above that we should know about?_____

_____

Have you consulted with an orthodontist previously? _____ Reason: _____

In your own words, describe your orthodontic problem and what you would like orthodontic treatment to accomplish: _____

_____

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs and send dentist information regarding diagnostic findings. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): _____ Date: _____