

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: _____

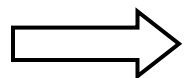
ID#: _____ Group#: _____ Insurance Co. Phone#: _____

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 <u>YES</u> :
<input type="checkbox"/> Latex Allergy <input type="checkbox"/> Tonsils or Adenoids Removed <input type="checkbox"/> Allergies/ Sinus Trouble <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> HIV Positive/ AIDS <input type="checkbox"/> TMJ Problems <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Emotional problems/ Psychiatric treatment	<input type="checkbox"/> Is the patient pregnant? <input type="checkbox"/> Has the patient reached puberty? <input type="checkbox"/> Thumb, finger, or lip sucking? (Please circle all that apply) <input type="checkbox"/> Mouth-breathing when awake or asleep? (Please circle all that apply) <input type="checkbox"/> Any injuries to the face, mouth, or teeth? (Please circle all that apply) <input type="checkbox"/> Any pain or popping when opening mouth? <input type="checkbox"/> Are you aware of an uncomfortable or bad bite? <input type="checkbox"/> Do you take any bisphosphate medication for osteoporosis? <input type="checkbox"/> 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: _____

