# 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 _____ ○ Male ○ Female Patient's Home Phone _____

Patient's Home Address _____ (Street) City, State, ZIP _____

Family Email _____ How did you hear about us? _____

Dentist's Name _____ Date of last visit _____

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? _____

Patient's attitude toward treatment? _____

## Parents Information

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

### Father

○ Father ○ Step Father ○ Guardian Name _____

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 _____

Insured's Name _____ Insured's Birth Date _____

### Mother

○ Mother ○ Step Moher ○ Guardian Name _____

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 _____

Insured's Name _____ Insured's Birth Date _____

## 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 | ○ Hepatitis |

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 If YES, explain _____

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.

Signature _____ Date _____