PATIENT INFORMATION (CHILD)

Date:_____

Patient's Name:_____
Last First Mi.

Address:_____
Street City Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____ Birthdate:_____ Age:_____

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

RESPONSIBLE PARTY INFORMATION

Name:_____
Last First Mi.

Mailing address (if different than patient):_____
Street City Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____ Social Security#: _____

Driver License #_____Relationship to Patient:_____

Employer:_____ Occupation:_____

Spouse's Name:_____
Last First Mi.

Mailing address (if different than patient):_____
Street City Zip

Home Phone:_____ Work Phone: _____ Cell Phone:_____

E-mail:_____ Social Security#: _____

Driver License #_____ Relationship to Patient:_____

Employer:_____ Occupation: _____

DENTAL INSURANCE

Insured's Name_____ Date of Birth:_____Subscriber #_____

Insurance Company_____ Group #_____ Local #_____

Insurance Co Address:_____ _____Phone #_____

Insured's Name_____Date of Birth:_____Subscriber #_____

Insurance Company_____ Group #_____ Local #_____

Insurance Co Address:_____Phone #_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____Phone #_____

Address_____Relationship:_____

DENTAL HISTORY

Dentist_____Phone_____ Date of last visit_____

Why did you bring the child to the Orthodontist today?_____
Has the child ever had a serious/difficult problem associated with dental work? Yes No
Is the child's water fluoridated? Yes No Is the child taking fluoridated supplements? Yes No
Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No
Does the child brush teeth? Yes No Floss their teeth daily? Yes No

MEDICAL HISTORY

Is the child currently under the care of a physician? Yes No
Describe the child's health? GOOD FAIR POOR
Physician:_____Date of Last Visit:_____

Address:_____Phone:_____
Please circle Yes or No (if yes, please fill in details)
YES NO Are you taking any medications?_____
YES NO Are you allergic to any medication?_____
YES NO Do you have a history of a major illness?_____
YES NO Have you had any major operations?_____
YES NO Have you ever been involved in a serious accident?_____
Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Epilepsy	Kidney Problems
Anemia	Gastrointestinal Disorders	Nervous Disorders
Arthritis	Handicaps/Disabilities	Pneumonia
Asthma/Hayfever	Hearing Impairment	Prosthesis
Bone Disorders	Heart Murmur	Prolonged Bleeding
Cancer	Heart Problems	Radiation/Chemotherapy
Congenital Heart Defect	Hepatitis/Liver Problems	Rheumatic Fever
Convulsions	Herpes	Scarlet Fever
Diabetes	High Blood Pressure	Tuberculosis
Dizziness	HIV/AIDS	Tumor

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Does the child have any of the following habits?
YES NO Thumb sucking/Finger sucking YES NO Nail Biting
YES NO Lip sucking/biting YES NO Nursing Bottle Habits

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of parent/guardian Date

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herin.

Responsible Party:_____ Date_____

Doctor's Comments:_____

Medical History Update:
1)Date_____ Signature_____Comments_____

2)Date_____Signature_____ Comments_____