

(CHILD)

**CONFIDENTIAL INFORMATION**

Date \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Residence/Mailing Address \_\_\_\_\_  
Street Apt/Unit #

How long at this address \_\_\_\_\_

City State Zip

Previous Address if less than 3 years \_\_\_\_\_

Home Phone \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Single/Married/Divorced

**Mother's Name** \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Residence/Mailing Address \_\_\_\_\_  
Street Apt/Unit #

How long at this address \_\_\_\_\_

City State Zip

Previous Address if less than 3 years \_\_\_\_\_

Home Phone \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Single/Married/Divorced

**Who will be responsible for the account?** \_\_\_\_\_

Relationship to patient (circle one) Mother/Father/Step Parent/Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Male/Female  
Last First MI

E-mail Address \_\_\_\_\_ Nickname \_\_\_\_\_

Primary Residence \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

If patient is a minor, give primary responsible party or legal guardian's name \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Dentist Phone \_\_\_\_\_  
First Last

Date of last visit \_\_\_\_\_ Whom may we thank for referring you to our office? \_\_\_\_\_

Have we treated any other family members in our office? \_\_\_\_\_ Names \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Hobbies/Sports \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**DOES YOUR DENTAL INSURANCE COVER BRACES? YES NO**

Member's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Member's Mailing Address \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

**DO YOU HAVE DUAL INSURANCE? IF YES:**

Member's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Member's Mailing Address \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_ Relation \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone # \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (responsible party's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

### MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
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 | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / Aids               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

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

### DENTAL HISTORY

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_  
Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_

How did they feel about the result? \_\_\_\_\_

What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_  
Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_  
Yes No If the patient is under age 16, height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_  
Yes No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_

Please list some hobbies or interests \_\_\_\_\_

Female Patients only: \_\_\_\_\_

Yes No Are you pregnant? \_\_\_\_\_  
Yes No Has menstruation started? \_\_\_\_\_

### BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. \_\_\_\_\_ to perform a complete orthodontic evaluation.

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