Child Patient Information

Patient's Name (Last, First):

Patient's Nickname: **Patient's Birthdate:**

Patient's Gender: Male ☐ Female ☐

Patient's Street Address:

Patient's Pediatric Dentist or General Dentist:

Has your child ever had an orthodontic evaluation?

What concerns you most about your child's teeth?

Does the patient have any siblings? What are their names and ages?

Any siblings currently undergoing orthodontic treatment?

Patient's School: **Patient's Hobbies:**

Which method(s) would you prefer to receive notifications for future appointments? Email ☐ Text ☐ None ☐

Whom may we thank for referring you to our office?

Billing Party Information
(Person financially responsible)

Please select: Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯

Billing Party's Name (Last, First):

Billing Party's Gender: Male ☐ Female ☐ **Billing Party's Birthdate:**

Billing Party's Social Security Number:

Billing Party's Address:

Billing Party's Primary Number: **Billing Party's Cell Number:**

Billing Party's Work Number: **Billing Party's Email Address:**

Marital Status: Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯

Relationship to Patient: Mother ◯ Father ◯ Aunt ◯ Uncle ◯ Grandmother ◯ Grandfather ◯ Guardian ◯

Occupation: **Employer:** **Number of years employed:**

Parent/Guardian
(Other than Billing Party)

Please select: Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ **Birthdate:**

Name (Last, First): **Gender: Male ☐ Female ☐**

Address: **Cell Number:**

CENTRAL PARK WEST ORTHODONTICS

Dental Insurance Information

If you have dental insurance, please provide the following information so we can verify your benefits before your scheduled appointment.

Primary Insurance Policy Coverage:

Policy Holder's Name (Last, First): **Policy Holder's Date of Birth:**

Policy Holder's Social Security Number: **Policy Holder's Contract Number:**

Employer's Name:

Insurance Company: **Group or Local Number:**

Insurance Company Phone Number and Address (where to mail claims to):

Medical History

Physician's Name (Last Name, First Name):

Physician's Phone Number: **Date of Last Visit:**

Describe what is your child's current health status?

Select any of the following medical/health concerns? (Check all that apply past/present)

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Artificial Bones/ Joints/ Valve
- ☐ Asthma / Arthritis
- ☐ Attention Deficit Disorder
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficult Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy/ Seizures / Fainting
- ☐ Fever Blisters / Herpes
- ☐ Handicap / Disabilities
- ☐ Heart Attack / Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High / Low blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Menstruation
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Puberty
- ☐ Radiation Treatment
- ☐ Rheumatic/ Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Sickle Cell Disease/ Traits
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ TMD
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Ulcers/ Colitis
- ☐ No Medical Con

Is the patient allergic to any of the following?

- ☐ Aspirin
- ☐ Any Metals / Plastics
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other (Please indicate in the in the entry below)

Other Allergies:

Please list any medications that your child is currently taking:

Any of the following dental concerns? (Check all that apply)

- ☐ Has the child ever sucked thumb or fingers?
- ☐ Is the child currently sucking thumb or fingers?
- ☐ Does the child breathe predominantly through the mouth?
- ☐ Does the child have any speech problems?
- ☐ Does the child clench or grind teeth (at night)?
- ☐ Does the child have pain or clicking upon closing the mouth?
- ☐ Has the child had any head or face injuries?
- ☐ Have any teeth been chipped due to accidents?
- ☐ Have you been informed of missing permanent teeth?
- ☐ Have you been informed of any extra teeth?
- ☐ Were any teeth (baby or permanent) removed by extraction?
- ☐ Any noticeable difficulty in chewing or swallowing food?
- ☐ Does your child bite/suck his/her lips?
- ☐ Does your child have Temporomandibular Joint Disorders?
- ☐ None

Does your child brush daily? How many times per a day?

Does your child floss daily? How many times per a day?

Has the child had tonsils / adenoids removed? If so when?

Discuss any other medical problems your child may have?

Emergency Contact Information

In case of an emergency, please provide the name of the nearest relative not living with you:

Emergency Contact's Name (Last, First):

Emergency Contact's relationship to patient:

Emergency Contact's Phone Number:

I affirm that the information I have given is correct to the best of my knowledge. 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 and updates to their account. I authorize the dental staff to perform the necessary dental service my child may need. I understand that I am responsible for payment of services rendered at this office. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Please sign and date:_____