Child Patient Information

Patient's Name (Last, First):_____ **Patient's Nickname:** _____

Patient's Date of Birth: _____ **Patient's Gender:** □**Male** □**Female** □**Non-Binary**

Patient's Street Address: _____

Patient's Pediatric Dentist or General Dentist (Required):_____

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? □**Yes** □**No**

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

Whom May We Thank For Referring You? □**Dentist** _____ □**Internet** _____

□ **Primary Doctor**_____ □**Friend** _____ □**Other** _____

Guardian 1

Please select: □**Dr.** □**Mr.** □**Mrs.** □**Ms.**

Guardian 1 Name (Last, First):

_____

Guardian 1 Birthdate:

_____

Guardian 1 Gender: □**Male** □**Female**

Guardian 1 Social Security Number:

_____

Guardian 1 Address: (□ Same as Patient)

_____

Guardian 1 Primary Number:

_____

Guardian 1 Cell Phone Number:

_____

Guardian 1 Work Number:

_____

Email Address:

_____

Marital Status: □**Single** □**Married**
□**Widowed** □**Separated** □**Divorced**

Employer:

_____

Relationship to Patient: _____

Guardian 2

Please select: □**Dr.** □**Mr.** □**Mrs.** □**Ms.**

Guardian 2 Name (Last, First):

_____

Guardian 2 Birthdate:

_____

Guardian 2 Gender: □**Male** □**Female**

Guardian 2 Social Security Number:

_____

Guardian 2 Address: (□ Same as Guardian #1)

_____

Guardian 2 Primary Number:

_____

Guardian 2 Cell Phone Number:

_____

Guardian 2 Work Number:

_____

Email Address:

_____

Marital Status: □**Single** □**Married**
□**Widowed** □**Separated** □**Divorced**

Employer:

_____

Relationship to Patient: _____

Which guardian is financially responsible for patient's treatment? ☐ Guardian 1 ☐ Guardian 2

Who is the primary contact for patient's treatment (i.e. scheduling appointments)? ☐ Guardian 1 ☐ Guardian 2 ☐ other (please provide cellphone and email): _____

Dental Insurance Information (Primary)

Policy Holder's Full Name: _____Policy Holder's Date of Birth: __ __/ __ __/ __ __ __ __

Employer's Name: _____ Policy Holder's SSN: ___ ___ ___ - __ __ - __ __ ___ ___

Insurance Company: _____Policy Holder ID Number: _____

Group Number: _____ Insurance Company Address: _____

Medical History

Physician's full name: _____

Physician's Phone Number: _____

Describe what is your child's current health status?_____ Date of last Visit: _____

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
- ☐ Transfusion Blood
- ☐ 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
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Menstruation
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Condition
- ☐ Radiation Treatment
- ☐ Rheumatic/ Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Sickle Cell Disease/ Traits
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ TMD
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Ulcers/ Colitis
- ☐ No Medical Conditions

Is the patient allergic to any of the following?

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

Other Allergies: _____

Please list any medication that your child is 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)?

☐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 the child have pain or clicking upon closing the mouth?

☐Does your child have Temporomandibular Joint Disorders?

☐Other _____

☐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 concerns your child may have: _____

Emergency Contact Information

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

Emergency Contact's Name (Last, First):_____

Emergency Contact's relationship to patient: _____

Emergency Contact's Phone Number:_____

Authorization for Release of Patient Information

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontics care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any future release by the individual receiving this information.
Please Initial: _____

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:_____