



PATIENT INFORMATION

Patient Name: _____
LAST FIRST MI

Preferred Name: _____

Gender: Male Female Non-Binary

Birthdate: ____/____/____ Age: _____

Home Address: _____

CITY STATE ZIP

Primary Phone Number: _____

Name of School: _____ Grade: _____

Please list any sports and or extracurricular activities including musical instruments played: _____

Siblings (Names & Ages) _____

PARENT/GUARDIAN INFORMATION MATERNAL

Name: _____
LAST FIRST MI

Relationship to Patient:
 Mother Step-Mother Guardian Other

Marital Status: S M D W SO

Address (If different than patient): _____

CITY STATE ZIP

Email: _____

Primary Phone Number: _____

Occupation: _____

Employer: _____

PARENT/GUARDIAN INFORMATION PATERNAL

Name: _____
LAST FIRST MI

Relationship to Patient:
 Father Step-Father Guardian Other

Marital Status: S M D W SO

Address (If different than patient): _____

CITY STATE ZIP

Email: _____

Primary Phone Number: _____

Occupation: _____

Employer: _____

RESPONSIBLE PARTY FOR ACCOUNT

Name: _____
LAST FIRST MI

Relationship to Patient:
 Mother Father Step-Mother Step-Father
 Guardian Other

Address (If different than patient): _____

CITY STATE ZIP

Primary Phone Number: _____

Social Security #: ____/____/____

Birthdate: ____/____/____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

CITY STATE ZIP

Insurance Co. Phone: _____

Group #: _____

Member ID #: _____

Policy Holders Name: _____

Relationship to Patient: _____

Policy Holders SSN: ____/____/____

Policy Holders Birthdate: ____/____/____

Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

CITY STATE ZIP

Insurance Co. Phone: _____

Group #: _____

Member ID #: _____

Policy Holders Name: _____

Relationship to Patient: _____

Policy Holders SSN: ____/____/____

Policy Holders Birthdate: ____/____/____

Employer: _____

(PLEASE COMPLETE BACK OF FORM)



DENTAL HISTORY

General Dentist: _____ Phone: _____

What was the date of their last visit: _____/_____/_____

How did you hear about our practice? Advertisement Internet Family/Friend Dentist Other

Whom may we thank for referring you (if applicable)? _____

What are the main concerns that you would like orthodontics to correct? _____

Has your child visited an orthodontist before? Yes No If yes, date/reason: _____

Have we treated other family members? If yes, please list their names: _____

Has your child's Tonsils Adenoids been removed?

Has your child ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? Yes No

If yes, please describe left/right or both. AM or PM: _____

Does your child have any missing or extra permanent teeth? Yes No

Has your child ever had injury to the following: (Select all that apply) Teeth Jaw Chin

Please describe injury: _____

Does your child have speech problems? Yes No If yes, reason: _____

Do they currently or have they ever had any of the following habits: (Check all that apply)

Clenching/Grinding teeth: Lip Sucking/Biting: Thumb/Finger Sucking: Mouth Breathing:

Tongue Thrusting: Nail Biting: Chewing/Eating Problem:

MEDICAL HISTORY

Is your child currently under a physician's care? Yes No If yes, explain: _____

Physician: _____ Phone: _____

What was the date of their last visit: _____/_____/_____

Does your child have any allergies or sensitivities? (ie medication, latex, nickel, etc)? Y N If yes, explain: _____

Is your child taking any medications at this time? Yes No If yes, explain: _____

Has puberty (males) or menstruation (females) begun? Yes No

Has your child had any serious illnesses or operations? Yes No If yes, explain: _____

Has your child ever had a blood transfusion? Yes No If yes, explain: _____

Please check if your child has ever had any of the following:

- | | | | | | |
|--|---|---|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling of Feet or Ankles | |

AUTHORIZATION - PLEASE SIGN & DATE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I hereby authorize the release of any information pertaining to my child's dental treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____