



**1. Please enter the child's information.**

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social security number: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Female  Male

Home address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred contact method: \_\_\_\_\_  
 Mobile Phone  Home Phone  Work Phone  
 Email

School: \_\_\_\_\_ Grade: \_\_\_\_\_

**2. List any sports or extracurricular activities:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Siblings (names and ages):**

	Name	Age		Name	Age
1			2		

**4. Parent Information:**

Parent/guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parents' marital status: \_\_\_\_\_ Social security number: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Single  Married  Domestic Partner  
 Separated  Divorced  Widowed

Driver's license number: \_\_\_\_\_ Phone number: \_\_\_\_\_ Phone type: \_\_\_\_\_  
 Cell  Home  Work

Parent/guardian address (if different than child's): \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_

Employer's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**5. Parent Information:**

Parent/guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parents' marital status: \_\_\_\_\_ Social security number: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Single  Married  Domestic Partner  
 Separated  Divorced  Widowed

Driver's license number: \_\_\_\_\_ Phone number: \_\_\_\_\_ Phone type:  
 Cell  Home  Work

Parent/guardian address (if different than child's): \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_

Employer's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**6. Emergency Contact Information:**

Emergency contact name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Emergency contact number: \_\_\_\_\_

Emergency contact address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_

**7. Person(s) OK to release appointment or medically related information to concerning child:**

	Name	Relationship		Name	Relationship
1			2		

**8. Primary Insurance Information:**

Primary insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone number: \_\_\_\_\_

Social security number: \_\_\_\_\_ Co-pay (if known): \_\_\_\_\_ Deductible (if known): \_\_\_\_\_

**9. Would you like to add Secondary Insurance?**

Yes

No

**10. Secondary Insurance Information:**

Secondary insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone number: \_\_\_\_\_

Social security number: \_\_\_\_\_ Co-pay (if known): \_\_\_\_\_ Deductible (if known): \_\_\_\_\_

**11. General dentist name:** \_\_\_\_\_ **Last visit:** \_\_\_\_\_

**12. How did you hear about our practice?**

- Internet                       Family/friend                       Dentist  
 Ad                                 Other:

**If other, please specify:**  
\_\_\_\_\_

**13. Who referred you (if applicable)?**  
\_\_\_\_\_

**14. What are the main concerns/goals you would like orthodontics to address/accomplish?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**15. Has your child visited an orthodontist before?**

- Yes  
 No

**16. If so, when and for what reason?**  
\_\_\_\_\_

**17. Have we treated any other family members? (If so, please list names.)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18.	Yes/No	If Yes, please explain:
Have your child's tonsils or adenoids been removed?		
Has your child ever experienced jaw joint pain/ discomfort (TMJ/TMD)?		
Does your child have any missing or extra permanent teeth?		
Does your child have speech problems?		
Do your child's gums bleed?		
Does your child smoke? (state #/day)		
Does your child like his/her smile (If no, please explain)		

19. Has your child ever had an injury to (select all that apply):

- Teeth
  Mouth
  Chin  
 None

20. Please explain any injury noted above:

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21. Does your child currently or have they ever had any of the following habits (check all that apply)

- Clenching/Grinding Teeth
  Lip Sucking/Biting
  Mouth Breathing  
 Nail Biting
  Thumb/Finger Sucking
  Chewing/Eating Problem

22. Is your child currently being treated by a physician?

- Yes  
 No

23. If your child is currently being treated by a physician:

Reason:

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Physician name:

Date of last visit:

Physician phone:

24. Does your child have any allergies/sensitivities to medications or latex?

- Yes
- No

25. If yes, please list:

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26. Is your child currently taking any prescription or over-the-counter medications?

- Yes
- No

27. Please list any Prescription or over the counter medications your child is taking:

	Medication Name	Dosage	Reason for Taking?
1			
2			
3			

28. Has puberty and/or menstruation begun?

- Yes
- No
- N/A

29. Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?

- Yes
- No

30. Has your child had any serious illnesses or operations?

- Yes
- No

31. Please list any serious illnesses or operations:

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**32. Has your child ever had a blood transfusion?**

- Yes
- No

If yes, give approximate dates:

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**33. Is your child:**

Pregnant?

- Yes
- No

Nursing?

- Yes
- No

Taking birth control?

- Yes
- No

**34. Check if your child has or has ever had any of the following:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial heart valves |
| <input type="checkbox"/> Artificial joints     | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Back problems           |
| <input type="checkbox"/> Blood disease         | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Chemical dependency     |
| <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> Circulatory problems  | <input type="checkbox"/> Cortisone treatments    |
| <input type="checkbox"/> Cough, persistent     | <input type="checkbox"/> Coughing blood        | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Hemophilia              |
| <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Jaw pain              | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Liver disease           |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Radiation treatment     |
| <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> Rheumatic fever       |  |

35. 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 medical status. I hereby authorize the release of any information pertaining to my medical 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.

Parent/Guardian Signature

\_\_\_\_\_

Signature

\_\_\_\_\_

Date