



PATIENT INFORMATION	Name of Child		Preferred Name	
	Date of Birth	Age	Gender: Male Female	
	School	Grade	Hobbies/Interests	
	Home Address		City	State
	Mailing Address		City	State
	Email Address		Home Phone	
	Whom may we thank for referring you?			
	General Dentist		Date of Last Visit	

FAMILY INFORMATION		Mother	Father				
	Name						
	Employer						
	Occupation						
	Home Address						
	Home Phone						
	Work Phone						
	Cell Phone						
	Email Address						
	Social Security #						
Date of Birth							
	Parents are: (Please Circle)	Married	Seperated	Divorced	Widowed	Single	
Name of person with whom patient lives							
Relationship to patient							
Patients siblings (Please list names and ages)							
Have we treated any of your family members in this office?							
If yes, please list their name(s)							
	Are there any other members of your family who would like an orthodontic evaluation?					Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please list their name(s) and age(s)							

FINANCIAL & INSURANCE INFORMATION	Which parent is responsible for financial matters in this office?		
	If the person responsible for financial matters is other than the parent, please complete the following:		
	Name	Employer	
	Home Address	Social Security Number	
	Home Phone	Work Phone	
	Is the patient covered by orthodontic insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes, please complete the following:		
	Insurance Company Name	Group Number	
	Policy Number	Where does the insured work?	
	Name of Insured	Social Security Number	Date of Birth
	Is there a secondary insurance policy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes, please provide details		

MEDICAL INFORMATION	Child's Physician	Phone Number	
	Does your child require antibiotic premedicator for dental treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Has your child reached puberty (menustration, hair, voice change)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Is your child allergic to latex or metal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Please list any other allergies your child has		
	Please discuss any medical problems that your child has had		
	Please list all medications your child is currently taking and reason for each		
	Emergency Contact Name	Phone	
	Relationship		

DENTAL HISTORY	What concerns you most about your child's teeth?		
	Has your child ever been evaluated for orthodontic treatment before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes, was treatment done?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Doctor's Name	Date Seen	
	Have there been any injuries to the face, mouth or chin?		
	Has your child ever had any pain or clicking in his/her jaw joint (TMJ/TMD)?		
	Has your child ever been treated for periodontal (gum) problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Is your child self-conscious about his/her teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Has your child had any of the following medical problems? (If yes, please check the box)		
	Clenching/Grinding Teeth <input type="checkbox"/>	Mouth Breather <input type="checkbox"/>	Speech Problems <input type="checkbox"/>
Difficulty Opening or Closing Mouth <input type="checkbox"/>	Thumb/Finger Sucking <input type="checkbox"/>	Tongue Thrust <input type="checkbox"/>	

OFFICE USE ONLY	Chief Complaint	
	Initials	Date
	I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.	
	Doctor's Comments	

AGREEMENT	This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agency.	
	Signature	Date