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**ORTHODONTICS**  
and Dentofacial Orthopedics

# Welcome to our practice!

We would like to welcome you and your child to our office. Our goal is to make your visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Please tell us about your child:

Today's date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Male  Female

Nickname: \_\_\_\_\_

Child's home phone #: \_\_\_\_\_ e-mail: \_\_\_\_\_

Child's home address: \_\_\_\_\_

City State Zip

Child's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_ Class of: \_\_\_\_

Hobbies/Sports: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Did they refer you to us?  Yes  No

Who is accompanying your child today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child? Yes  No

List brothers / sisters and ages: \_\_\_\_\_

Parents' Martial Status:  single  married  widowed  divorced  separated

Mother's Information  Step Mother  Guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_ Home#: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ How long at current job: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ DL#: \_\_\_\_\_

Father's Information  Step father  Guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_ Home#: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ How long at current job: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ DL#: \_\_\_\_\_

Person responsible for account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ SS# or /ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk#: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Who will be making appointments? \_\_\_\_\_ Best time to call? \_\_\_\_\_

Name: \_\_\_\_\_ Wk#: (\_\_\_\_) \_\_\_\_\_ Hm#: (\_\_\_\_) \_\_\_\_\_



**Primary Orthodontic Insurance** Coverage?   yes   no  
 Insurance Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy owner's name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SS# or ID #: \_\_\_\_\_ Policy owner's employer: \_\_\_\_\_

**Secondary Orthodontic Insurance** Coverage?   yes   no  
 Insurance Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy owner's name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SS# or ID #: \_\_\_\_\_ Policy owner's employer: \_\_\_\_\_

What are the main concerns that you would like orthodontics to address? \_\_\_\_\_

Has your child ever been evaluated for or had orthodontic treatment before?   Yes   No  
 Have there been any injuries to the face, mouth, teeth or chin?   Yes   No  
 List any musical instruments played: \_\_\_\_\_  
 Has your child been informed of any missing or extra permanent teeth?   Yes   No  
 Has your child ever had any pain / tenderness in his/ her jaw joint (TMJ/TMD)?   Yes   No  
 Does your child brush his /her teeth daily?   Yes   No  
 Floss his/ her teeth daily?   Yes   No  
 Child's Physician: \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 Is your child currently under the care of a physician?   Yes   No  
 Has puberty begun?   Yes   No  
 Has menstruation begun? (Girls)   Yes   No  
 Please describe your child's current physical health:    Good    Fair    Poor  
 Please list all drugs that your child is currently taking: \_\_\_\_\_  
 Has your child ever had any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding			Diabetes			Asthma		
Handicaps/Disabilities			Hemophilia			Hearing impairment		
Allergies to any drugs			Heart Murmur			Any hospital stays		
Allergy to Latex/ Metals			Any operations			Hepatitis		
Any other allergies?			HIV + / AIDS			Cancer		
Kidney/liver problems			Congenital heart defect			Rheumatic/ Scarlet fever		
Convulsions/ Epilepsy			Tuberculosis (TB)					

Please comment on any (Yes) answers \_\_\_\_\_

Please list any habits (thumb, finger sucking, nail biting, etc.) that your child has or had in the past. \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_