

Child Patient Information



We would like to welcome you and your child to our office.
Our goal is to make everyone's visit pleasant and educational.
Please fill out the information below:

Today's Date _____

Child's name _____ Nickname _____
LAST FIRST MI

☐ Male ☐ Female Birth date _____ Age _____ Home # _____ Cell # _____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

School _____ Grade _____

Hobbies/Sports _____

Who is accompanying your child today? _____ Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Please list your child's siblings' names and ages _____

General dentist _____ Date of Last Visit _____

Parent's marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Mother's Information ☐ Mother ☐ Stepmother ☐ Guardian ☐ Other _____

Name _____ SS# _____ Home # _____ Cell # _____ Birth date _____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

E-mail _____ Employer _____ Work # _____

Job title _____

Father's Information ☐ Father ☐ Stepfather ☐ Guardian ☐ Other _____

Name _____ SS# _____ Home # _____ Cell # _____ Birth date _____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

E-mail _____ Employer _____ Work # _____

Job title _____

Person Responsible for Account _____ SS# _____

Home # _____ Cell # _____ Relationship _____

Home Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

Previous Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

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Primary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

Secondary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

Child's Health History

What are the main concerns that you would like the orthodontist 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

Have adenoids and/or tonsils been removed? ☐ Yes ☐ No

Has your child ever had any of the following diseases/medical problems?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip sucking/biting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergic to latex/metals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nail biting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies to any drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic/scarlet fever
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thumb/finger sucking
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching/grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue thrust
<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital heart defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/liver problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (TB)

Please discuss any medical conditions that your child may have _____

Child's physician _____ Phone # _____

Date of last visit _____ Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health ☐ Good ☐ Fair ☐ Poor

Please list any prescriptions/over the counter drugs your child is taking _____

Please list any drugs/materials/foods/flavorings (mint, cinnamon, etc.) that your child is allergic to _____

I understand the information 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 _____ Date _____

Doctor's Comments _____