

Child Patient Information Form

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Patient Name _____ Nickname _____

Address _____ City _____ Zip _____

Age _____ Birth Date _____ Sex _____ School _____ Grade _____

Mother's Name _____ Employed by _____

Occupation _____

Home Phone _____ Cellular phone _____ Business phone _____

Father's Name _____ Employed by _____

Occupation _____

Home Phone _____ Cellular phone _____ Business phone _____

Alternate Address: _____ City _____ Zip _____

If not married are the patient's parents..... Divorced Separated

If the parents live apart does the patient live with.....Mom Dad Other _____

Person Financially Responsible _____ Relationship to patient _____

Address _____ City _____ Zip _____ Phone _____

Is the patient covered by insurance for orthodontic treatment? Yes No Unknown

Primary Dental Carrier _____ Group # _____

Insured Name _____ Birth date _____ Soc.Sec.# _____

Secondary Dental Carrier _____ Group # _____

Secondary Insured Name _____ Birth date _____ Soc.Sec.# _____

Do you anticipate a move or transfer in the near future Yes No

Names and ages of other children in the family: _____

Musical instruments played _____ Sports _____ Hobbies _____

MEDICAL HISTORY

Patient's Physician _____

Patient's height _____ Patient's Weight _____ Most recent physical examination _____

Any changes in health in the last year Yes No (If yes explain below) _____

Any operations, accidents, or hospitalizations? _____

List any medications, nutrient supplements or non prescription medicine taken now or in the past? yes no (If yes explain) _____

List drug sensitivities, reactions to dental anesthetics, or any allergies _____

- yes** **no** Birth defects or hereditary problems?
- yes** **no** Rheumatoid or arthritic conditions?
- yes** **no** Endocrine or thyroid problems?
- yes** **no** Kidney problems?
- yes** **no** Diabetes?
- yes** **no** Cancer or treated for a tumor?
- yes** **no** Hepatitis, jaundice or liver problem?
- yes** **no** AIDS or HIV Positive?
- yes** **no** Fainting spells, seizures, epilepsy or neurological disease?
- yes** **no** Mental health or behavioral problems?
- yes** **no** Vision, hearing, tasting or speech difficulties?
- yes** **no** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
- yes** **no** High or low blood pressure?
- Yes** **no** Cardiovascular problems (heart trouble, stroke, heart defects or rheumatic heart)

- yes** **no** Eye, ear, nose, throat condition?
- yes** **no** Hay fever, asthma, sinus trouble, hives?
- yes** **no** Tonsil or adenoid conditions?
- yes** **no** Allergies or drug reactions?
- yes** **no** Substance abuse problem?
- yes** **no** Tuberculosis or communicable disease
- yes** **no** Other physical problems or symptoms?
- yes** **no** Treatment for any conditions not listed above? _____

Growth

Girls- Has she started menstruation?.....**Yes/No**
If yes, at what age? _____

yes **no** Pregnant or history of pregnancy

Boys- Has his voice changed?.....**Yes/No**
If yes, at what age? _____

Please describe any illnesses or conditions circled yes above including when contracted and whether currently under treatment as well as conditions not listed above _____

Dental History

Dentist _____ Date of most recent dental exam _____

How often does the patient see their dentist? Every.... 3 month's..... 6 month's..... 9 month's..... 1 year

- | | |
|---|---|
| <input type="checkbox"/> yes <input type="checkbox"/> no Chipped or otherwise injured permanent teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no Periodontal (gum) surgery treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no History of decayed or abscessed teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no "TMJ" (jaw joint) problems or facial muscle pain)? |
| <input type="checkbox"/> yes <input type="checkbox"/> no Teeth sensitive to hot or cold; teeth throb or ache? | <input type="checkbox"/> yes <input type="checkbox"/> no Tooth grinding, jaw clenching, clicking, locking? |
| <input type="checkbox"/> yes <input type="checkbox"/> no Extra or congenitally missing teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no Difficulty chewing, jaw opening or closing with pain or noise? |
| <input type="checkbox"/> yes <input type="checkbox"/> no Jaw fractures, cysts, mouth infections? | <input type="checkbox"/> yes <input type="checkbox"/> no Mouth breathing habit, snoring, difficulty in |
| <input type="checkbox"/> yes <input type="checkbox"/> no Cold sores, Canker sores, mouth ulcerations? | <input type="checkbox"/> yes <input type="checkbox"/> no Any history of speech problems? |
| <input type="checkbox"/> yes <input type="checkbox"/> no Periodontal "Gum Problems", gum pocketing? | |

Yes **No**

Have any teeth been removed by the dentist.....

Thumb or finger sucking habit.....

If yes at what age did they stop? _____

Has an orthodontist been consulted previously.....

Has the patient had any orthodontic treatment

If yes please provide details _____

Dentist planning for..... Fillings Crowns Implants Bridges gum treatment tooth extractions

Chief Complaint

Patients often need changes in their bites, appearance of teeth, or relationship of the teeth to the face. Please help us understand the patient's problem.

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that you feel might be encountered during treatment? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

We wish to inform you in advance that as part of our routine business procedure, our office contracts with Equifax to conduct a cursory credit history on the responsible party for each of our patients prior to treatment.

If there are any changes later to this child's medical/dental status, I will inform this practice.

Parent's Signature _____ Date _____ Relationship to patient _____

Doctor's Signature _____ Date _____

Review of medical and dental history

Changes Yes No If Yes describe _____

Parent's Signature _____ Date _____ Doctor's Signature _____ Date _____

Changes Yes No If Yes describe _____

Parent's Signature _____ Date _____ Doctor's Signature _____ Date _____