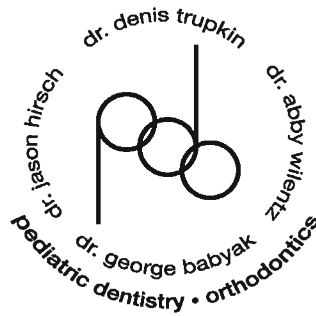
Date ____________________

Chart # ________________

Child Information Form

WELCOME. To assist us in providing the most complete service, please provide the following information and health history.



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PERSONAL INFORMATION

Name ______________________________ Nickname ______________

Address ______________________________ City/Zip ______________

Sex ____________ Age ____________ Date of Birth ______________

School ______________________________ Grade ______________

Brothers/Sisters (Name and Age) ______________________________

Dentist ____________ Phone ____________ Physician ____________ Phone ____________

Referred by ____________________ Patients Email ____________________

Marital Status of Parents ❑ Single ❑ Married ❑ Seperated ❑ Divorced ❑ Remarried ❑ Widowed

Patient Lives with ❑ Both Parents ❑ Mother ❑ Father ❑ Other ______________

Person Responsible for Acct ____________________ Phone # ______________

Mother / Guardian	**Father / Guardian**
Name ____________________	Name ____________________
Address ____________________	Address ____________________
City/State/Zip ____________________	City/State/Zip ____________________
Home Phone ____________________	Home Phone ____________________
Cell Phone ____________________	Cell Phone ____________________
Employed by ____________________	Employed by ____________________
Occupation ____________________	Occupation ____________________
Work Phone ____________________	Work Phone ____________________
Date of Birth ____________________	Date of Birth ____________________
S.S. # ____________________	S.S. # ____________________
Parent's Email ____________________	Parent's Email ____________________

Member American Association of Orthodontics

Please complete other side

MEDICAL HISTORY

Please check box if patient has or has had:

- ❑ Tonsils removed
- ❑ Joint swelling
- ❑ Bone disorders
- ❑ Heart trouble
- ❑ Rheumatic fever
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Emotional problems
- ❑ Brain injury
- ❑ Kidney or liver involvement
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Asthma
- ❑ Epilepsy
- ❑ Prolonged bleeding
- ❑ Faintness/Dizziness
- ❑ Positive HIV test
- ❑ Adenoids removed
- ❑ Sore throats
- ❑ Tonsillitis
- ❑ Earaches

List any conditions we should be aware of: ________

____

____

List any allergies: ________________________

____

List drugs or medications now being taken: ________

____

Is patient under physicians care presently? ______

Reason: ________________________

Name of physician: ________________________

Approximately how much has patient grown in the last year:

____

DENTAL HISTORY

Please check box if answer is yes:

- ❑ Any injuries to face, mouth, teeth? (circle)
- ❑ Thumb, finger, lip sucking? (circle)
- ❑ Mouth-breathing when asleep, awake? (circle)
- ❑ More than average amount of decay?
- ❑ Any missing permanent teeth?
- ❑ Any extra permanent teeth?
- ❑ Any teeth removed by extraction?
- ❑ Is there any tongue-thrusting problem?
- ❑ Any speech problems?
- ❑ Any difficulty in swallowing or chewing?
- ❑ Any pain or clicking on opening mouth?
- ❑ Is patient adopted? At what age? __________
- ❑ Does patient visit dentist regularly?

Date of last dentist visit ______________

- ❑ Has an orthodontist been consulted previously?

Reason: ________________________

____

____

List any wind instrument played:

____

Sports: ________________________

Hobbies: ________________________

Other family members treated: ________________

____

Additional Comments: ____

GIRLS ONLY: Has the patient started her monthly periods? ❑ Yes ❑ No ❑ DK/U

If so, approximately when? ________________________

Please note any other factors the doctor should know about the patient's dental/medical health: ____________

____

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.) __________

____

Please describe reasons for considering orthodontic treatment:

- ❑ Improve facial appearance
- ❑ Improved functional health
- ❑ Enhanced long-term dental health
- ❑ Other: ________________________

Describe your child's attitude toward orthodontic treatment:

- ❑ Wants it done
- ❑ Does not want it done
- ❑ Does not care
- ❑ Other: ________________________

Patient Authorization - PLEASE SIGN BELOW

I understand that the information that I have given is correct to the best of 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.

This office reserves the right to verify the 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 services.

X ________________________________

Signature of parent or guardian **Date**

I authorize the dental staff to perform the necessary dental services my child may need.

X ________________________________

Signature of parent or guardian **Date**

If this office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

X ________________________________

Signature of parent or guardian **Date**

The parent or Guardian who accompanies the child is responsible for payment.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.