

Child

Date: _____ Time: _____

Patient
 Name: _____ Nickname: _____ Sex: _____ Age: _____ Birthdate: ____-____-____
 Address: _____
 Home Phone: _____ School: _____ Grade Level: _____
 Parents Married? Yes No If no, patient lives with? Mother Father Other Names of Siblings (age): _____ ()
 _____ () _____ () _____ () _____ ()
 Who will bring patient to office most often? Mother Father Self Other E-Mail: _____

Mother's
 Name: _____ Home Phone if not the same: _____
 Address (if not the same): _____ Work Phone: _____ Ext. _____
 Occupation: _____ Employer: _____ Okay to call @ work? Yes No
 Orthodontic Insurance: _____ Birthdate _____ S. S. # ____-____-____

Father's
 Name: _____ Home Phone if not the same: _____
 Address (if not the same): _____ Work Phone: _____ Ext. _____
 Occupation: _____ Employer: _____ Okay to call @ work? Yes No
 Orthodontic Insurance: _____ Birthdate _____ S. S. # ____-____-____

Who referred you to us? _____ Family members we have seen: _____
 Who is your dentist? _____ Last Cleaning? _____ Months since last panoramic x-ray taken? _____
 Has the patient had orthodontic treatment? Yes No If so, who was the doctor? _____ When? _____

Do you have, or have you had any of the following?

- | | | | | | |
|----------------------|--|------------------------------|--|----------------------|--|
| Heart disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Breathing problems? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> | AIDS? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Current thumb habit? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High blood pressure? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Clicking jaw joints? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Past thumb habit? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hepatitis? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Frequent headaches? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Speech problems? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic fever? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Difficulty chewing? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Gum disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Allergies _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | Grinding or clenching teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other: _____ | |
| Heart murmur? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Morning jaw stiffness? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | |
| Diabetes? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pain in the jaw joints? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | |
| Stroke? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsillectomy? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | |

Name of Physician: _____ Are you under the care of a doctor? Yes No
 If so, for what? _____

Please list all medication being taken: _____

I the undersigned have given the information, have reviewed it, and find it accurate.

****In signing this, I grant permission for credit approval.****

SIGNATURE OF PATIENT OR RESPONSIBLE ADULT

DATE