PLEASE COMPLETE EACH LINE.

CHILD FORM

	PATIENT
NAME	
NICKNAME	
ADDRESS: Street	
City and Zip Code	
HOME PHONE	
BIRTHDATE	
AGE	
SCHOOL & GRADE LEVEL	
DENTIST	
DENTIST ADDRESS	
PHYSICIAN	
Who referred you to our office?	
LEGAL GUARDIAN	
BROTHERS (NAME & AGE)	
SISTERS (NAME & AGE)	

RESPONSIBLE PARTY INFORMATION

	FATHER	MOTHER
NAME		
SOCIAL SECURITY NUMBER		
DATE OF BIRTH		
RESIDENCE: STREET		
City and Zip Code	❑ SAME AS ABOVE	❑ SAME AS ABOVE
MAILING ADDRESS		
HOME PHONE NUMBER		
CELL PHONE		
EMPLOYER		
EMPLOYER ADDRESS:		
Street, City and Zip Code		
WORK PHONE NUMBER		
How long with present employer?		
How long at home address?		
DENTAL INSURANCE CO. NAME		
INSURANCE CO.:		
Street, City and Zip Code		
INSURANCE CO. PHONE NUMBER		
Does your insurance cover braces?	Yes ❑ No ❑	Yes ❑ No ❑

Person responsible for account? _____

Has any member of your family been a patient in this office? Yes ❑ No ❑

Names: _____

Friends who are in our office: Names: _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
❑	❑	Diabetes	❑	❑	Anemia	❑	❑	Prolonged Bleeding
❑	❑	Pneumonia	❑	❑	Epilepsy	❑	❑	Nervous Disorders
❑	❑	Heart Trouble	❑	❑	Asthma	❑	❑	Hepatitis
❑	❑	Rheumatic Fever	❑	❑	Kidney Involvement	❑	❑	Endocrine Problems
❑	❑	Bone Disorders	❑	❑	Tuberculosis	❑	❑	Frequent Colds and/or Flu
❑	❑	Adenoids Removed Age _____	❑	❑	Fainting or Dizziness	❑	❑	HIV Positive
❑	❑	Tonsils Removed Age _____	❑	❑	AIDS	❑	❑	Thyroid Problems
❑	❑	Emotional Problems						

List any other serious illnesses or medical problems.

List any allergies(including those to any drugs or medications).

List any drugs or medications now being taken.

DENTAL HISTORY

	Yes	No	
Has the patient ever sucked a thumb or finger?	❑	❑	Until what age?_____
Does the patient have any speech problems?	❑	❑	Any speech therapy? ❑ ❑ Yes No
Does the patient clench or grind the teeth (at night)?	❑	❑	
Does the patient have pain or clicking upon opening or closing the mouth?	❑	❑	
Has the patient ever had the jaw lock in the open or closed position?	❑	❑	
Has the patient had any severe head or face injuries?	❑	❑	
Does the patient, suffer from a frequent sore neck, back or headaches?	❑	❑	
Have any teeth been injured or chipped due to accidents?	❑	❑	
Have you been informed of any extra permanent teeth?	❑	❑	
Is there any noticeable difficulty in chewing or swallowing food?	❑	❑	
Would the patient mind wearing braces?	❑	❑	
Are you aware of any tongue thrusting problems?	❑	❑	
Are you aware that some appointments will infringe upon school time?	❑	❑	
Has the patient consulted with another orthodontist?	❑	❑	
Has the patient had any other orthodontic treatment?	❑	❑	
Date of last dental appointment_____Were x-rays taken?	❑	❑	

What would you like treatment to accomplish? _____

_____

I UNDERSTAND WHERE APPROPRIATE
CREDIT BUREAU REPORTS MAY BE OBTAINED Signature _____ Date:_____

• • • DO NOT WRITE BELOW THIS LINE • • •

Range of Motion	R_____	L_____	Opening_____	A	B	C
Clicking in Joints	Yes_____	No_____				
Headaches	Yes_____	No_____				
TMJ Disorder	Yes_____	No_____				

Notes: _____

_____

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