Patient Information

Patients Under Age 18

GENERAL INFORMATION: Date _____

Patient's Name (Last) _____ (First) _____(Middle) _____

Street Address _____Town _____ Zip Code _____

Mailing Address (if different) _____

Nickname _____ Age _____ Birthdate _____ M/F_____

Home Phone _____

Cell Phone_____

School Attending_____ Town_____ Grade_____

Whom May We Thank for Referring You? _____

Relatives Treated Here_____

Hobbies _____

Siblings/ages_____

Other family treated here (name & relation) _____

_____

PARENT INFORMATION:

Father's Name _____ Birthdate _____

Address_____

Email Address_____

Father's Cell Phone _____

Employer _____Employer's Address _____

Mother's Name _____ Birthdate_____

Address_____

Email Address_____

Mother's Cell Phone_____

Employer _____Employer's Address _____

Parent Marital Status: Single _____ Separated _____ Married _____ Divorced _____ Widowed _____

PRIMARY CONTACT Name _____

Best Contact #_____

MEDICAL INFORMATION:

Child's Dentist _____

Dental Practice Name_____

Dentist Address _____ Phone_____

Date of Last visit_____ Date of Last Cleaning_____

Child's Pediatrician _____

Pediatric Practice Name_____

Doctor Address _____ Phone _____

Date of Last Visit_____ Date of Last Physical _____

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. Periodic updates will be requested throughout treatment.

Is your child currently being treated for any condition? If yes, explain _____

_____

Is your child taking medications, vitamins or drugs? If yes, explain _____

_____

Has your child ever been hospitalized or had surgery? If yes, explain _____

_____

Y	N		Y	N		Y	N	
___	___	AIDS/HIV or STI	___	___	Convulsions/Seizures	___	___	Hereditary Issues
___	___	Bone fractures/injuries	___	___	Arthritis or joint problems	___	___	Kidney problems
___	___	Asthma	___	___	Diabetes or high/low blood sugar	___	___	Hemophilia
___	___	Allergies	___	___	Epilepsy	___	___	Hepatitis or
___	___	Birth Defects	___	___	Eye Problem			Liver Disease
___	___	Blood Transfusions	___	___	Excessive bleeding, bruising	___	___	Hyperactivity
___	___	Bone or Joint Problems	___	___	Excessive gagging	___	___	Oral Ulcers
___	___	Cancer, tumor	___	___	Orthopedic Problems			canker sores
___	___	Child Abuse	___	___	Fainting or Dizziness	___	___	Premature Birth
___	___	Chronic Adenoid/Tonsil	___	___	Growth/Development	___	___	Rheumatic Fever
		Infection			delays	___	___	Tuberculosis
___	___	Chronic Headache	___	___	Hearing loss, deaf, Speech	___	___	Handicap
___	___	Cleft Lip/Palate			difficulty	___	___	Lyme Disease
___	___	Congenital Heart Disease	___	___	Heart Murmur	___	___	Stomach Ulcer,
___	___	Immune System Issues	___	___	Osteoporosis			hyperacidity, reflux
___	___	Polio, mononucleosis	___	___	Tuberculosis, pneumonia	___	___	Mental health disturbance,
___	___	History of eating disorder	___	___	High or low blood pressure			depression
___	___	Frequent headaches	___	___	Skin disorder (other than acne)	___	___	Tobacco use
___	___	Frequent ear infections	___	___	Tonsil, adenoid condition	___	___	Sinus Problems
___	___	Neurological issues	___	___	Chest pain, short of breath	___	___	Female- Are you pregnant
___	___	Reached Puberty	___	___	Have/ever had substance abuse	___	___	ADD/ADHD
___	___	Allergy to latex, metal, plastic	___	___	Pacemaker	___	___	Other

Please explain any **"yes"** answer_____

Has there ever been trauma or injury to the face, head, neck and/or teeth? If yes, explain

_____

Anything else you want us to know_____

_____

RELEASE AND WAIVER

I authorize release of information regarding my child's orthodontic treatment to my dental and/or medical insurance co.

Parent/Guardian Signature _____Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her office team responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical/dental health or personal information.

Parent/Guardian Signature _____Date _____

UPDATES/CHANGES

Change_____

Signature_____Date_____

Change_____

Signature_____Date_____

Change_____

Signature_____Date_____

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