PLEASE COMPLETE BOTH SIDES OF THIS FORM AND BRING IT TO YOUR APPOINTMENT. THANK YOU.

Please describe you child's orthodontic problem and your concerns: ____
____

Patient's Name ______________________________ Nickname______________________________
Address ______________________________ City ______________________ Zip__________
Home Phone ______________________________ Birthdate ______________________ Age__________
Hobbies and Interests ______________________ School______________________ Grade __________
Patient lives with: ___ Both Mother and Father ___Mother ___Father ___Other ______________
Brothers' and Sisters' Names and Ages____

FAMILY INFORMATION

Father

Last Name ______________________ First __________
Address, if different ______________________________
City __________________ State ______ Zip__________
Home Phone ______________________________
Social Security Number ______________________________
Employer's Name ______________________________
Business Address ______________________________
____
Business Phone ______________________________
Occupation ______________________________

Mother

Last Name ______________________ First __________
Address, if different ______________________________
City __________________ State___ Zip__________
Home Phone ______________________________
Social Security Number ______________________________
Employer's Name ______________________________
Business Address ______________________________
____
Business Phone ______________________________
Occupation ______________________________

Person responsible for account if other than parent:

Name ______________________________ Social Security Number ______________________
Address ______________________________ City ______________________ State___ Zip__________
Home Phone ______________________________ Relationship to patient ______________________
Employer's Name ______________________________ Business Phone ______________________
Business Address ______________________________ City ______________________ State ___ Zip __________

ORTHODONTIC INSURANCE INFORMATION

Primary Coverage:

Name of Insured (Employee) ______________________________ Birthdate ______________________________
Name of Insurance Company ______________________________ Group # ______________________________
Insurance Billing Address ______________________________ City______________________ State ___ Zip__________
Insurance Phone Number ______________________________ SS#______________________________

Secondary Coverage:

Name of Insured (Employee) ______________________________ Birthdate ______________________________
Name of Insurance Company ______________________________ Group # ______________________________
Insurance Billing Address ______________________________ City ______________________ State ___ Zip __________
Insurance Phone Number ______________________________ SS# ______________________________

MEDICAL HISTORY

Physician's Name ______________________________ Phone ______________________________

	Yes	No
Has your child experienced any health problems?	___	___
Any major change in your child's health recently?	___	___
Is your child currently under a physician's care?	___	___
Is your child taking medications regularly?	___	___
Is your child allergic to any medications?	___	___
Have your child's tonsils or adenoids been removed?	___	___

Please check if your child now has or has ever had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Heart Murmur	___	___	Sinus Problems	___	___	Blood Pressure Problems	___	___
Heart Surgery	___	___	Hepatitis	___	___	Frequent Headaches	___	___
Rheumatic Fever	___	___	Diabetes	___	___	Nervous Disorders	___	___
Herpes	___	___	Kidney Disease	___	___	Fainting or Dizziness	___	___
AIDS or ARC	___	___	Liver Disease	___	___	Bone Disorders	___	___
Anemia	___	___	Tuberculosis	___	___	Growth Disorders	___	___
Blood Disease	___	___	Asthma	___	___	Prolonged Bleeding	___	___

Is there any other condition or problem that you feel we should be aware of?______________________________
____

DENTAL HISTORY

Patient's general dentist: ______________________________

Frequency of dental checkups: ___ Never ___ Only if a problem exists ___ Once a year ___ Twice a year

Date of last dental exam and cleaning: ______________________________

	Yes	No
Is there any dental work to be completed with your child's general dentist?	____	____
Has your child had any face or dental injuries?	____	____
Does your child have any speech problems?	____	____
Does your child breathe through his/her mouth more than his/her nose?	____	____
Is there any history of thumb or finger sucking?	____	____
Have you been informed of any missing or extra teeth?	____	____
Is there any history of gum disease?	____	____
Do your child's gums bleed frequently when his/her teeth are brushed?	____	____
Does your child bite his/her fingernails?	____	____

Please check if there is a history of the following conditions:

___ Clenching teeth ___Muscular soreness around head & neck ___ Jaw joint soreness ___ Jaw joint popping
___ Grinding teeth ___ Headaches (more than normal) ___ Jaw joint clicking ___ Recurrent ringing in ears

Has your child ever had an orthodontic exam before?_________ When?______________________________
With Whom?______________________________

Has your child ever had orthodontic treatment before?________ If yes, please describe______________________________
____
____

To the best of my knowledge, all of the preceding answers are true and accurate. If the patient ever has any change in health or change in medication, I will inform the orthodontist at the next appointment. The information on this form may be used to establish my credit.

Signature of Parent or Guardian ______________________________ Date ______________________________