William D. Nguyen, D.D.S, M.S.D.
Specialist in Orthodontics

CHILD/ADOLESCENT PATIENT INFORMATION

Exam Date_____/_____/_____

Patient's Name_____ ☐ M ☐ F Nickname_____
Last First Middle

Birthdate_____/_____/_____ Age_____ SSN_____-_____-_____ School_____ Grade_____

Address_____
Street City State Zip

If patient is a minor, give parent or guardian's name_____

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Name_____ Marital Status_____
Last First Middle

Address_____
Street City State Zip

How long at this address?_____ Home Ph_____ Cell/W Ph_____ Email_____

Previous Address (if less than 3 yrs)_____
Street City State Zip

Birthdate_____/_____/_____ SSN_____ - _____ - _____ Occupation_____ Relationship to Patient_____

Employer_____ Address_____
Street City State Zip

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Birthdate_____/_____/_____ SSN_____ - _____ - _____ Occupation_____ Cell/W Ph_____

Employer_____ Address_____
Street City State Zip

INSURANCE INFORMATION AND AUTHORIZATION

Insured's Name_____ _____ Insured's SSN_____

Insurance Company_____ Group Number_____

Ins Company Address_____ Phone_____

Insured's Employer_____ Secondary Coverage? ☐ Y ☐ N

If Yes: Insured's Name_____ Insured's SSN_____

Insurance Company_____ Group Number_____

Ins Company Address_____ Phone_____

Insured's Employer_____

I assign directly to Dr. Nguyen my insurance benefits for services rendered. I hereby authorize the Doctor and Staff to release information necessary to secure payment of benefits, and authorize the use of this signature on insurance submissions.

Signature (parent to sign for minor)_____ Date_____/_____/_____

EMERGENCY INFORMATION

Person to notify in an emergency:_____ Phone_____

Complete Address_____

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CHILD/ADOLESCENT HEALTH QUESTIONAIRE

Patient's Name_____ Date_____ Present at Exam ☐ Mother ☐ Father Other_____

What is your chief concern?_____

Physician_____ Dentist_____ Date of last dental exam_____

Who first noticed the need for an orthodontic examination? ☐ Dentist ☐ Parent ☐ Patient

DENTAL HISTORY

			EXPLANATION
Has anyone in the family ever had orthodontic treatment?	Y	N	
If so, has the result been stable and satisfactory?	Y	N	
Has the patient had any teeth removed?	Y	N	
Is the patient concerned about the appearance of the teeth?	Y	N	
Is the patient worried about receiving orthodontic treatment?	Y	N	
Has the patient had any previous orthodontic treatment or consultation?	Y	N	
Does the patient have difficulty with chewing and swallowing food?	Y	N	
Does the patient have any speech problems?	Y	N	
Has the patient ever sucked a thumb or finger? If yes, until what age?	Y	N	
Does the patient bite lips, tongue, fingernails, pencils, or other objects?	Y	N	
Does the patient breathe through the mouth?	Y	N	
Do the gums bleed easily?	Y	N	
Has the patient ever received a severe blow to the teeth or jaws?	Y	N	
Have there been any other injuries to the face, mouth, or teeth?	Y	N	
Does the patient have frequent earaches or soreness around the ears?	Y	N	
Has the jaw ever locked open or closed?	Y	N	
If so, when did it first occur?	Y	N	
Do you consider the patient to be under more stress than his/her peer?	Y	N	
Does the patient have difficulty in opening mouth wide?	Y	N	
Does the patient play a musical instrument? If so, which instrument?	Y	N	
Does any other family member have a similar bite problem as the patient?	Y	N	
TO HELP DETERMINE YOUR CHILD'S GROWTH POTENTIAL:			
Has the patient reached puberty?	Y	N	
Height _____ Weight _____			
Girls—has she started menstruation? When? _____	Y	N	
Boys—has his voice changed? When? _____	Y	N	

Names and birthdates of other children in the family. Include heights of older natural siblings.	Name	Birthdate	Height	Name	Birthdate	Height

MEDICAL HISTORY

Is the patient in good health?	Y	N	
Does the patient have any allergies or drug sensitivities? Please explain	Y	N	
Does the patient have a tendency to colds, sore throat, or ear infections?	Y	N	
Have tonsils and adenoids been removed? At what age?	Y	N	
Any drug or medications now being taken? If so, please list	Y	N	
Does the patient require pre-medication with antibiotics for dental work?	Y	N	
Is there any other health condition that Dr. Nguyen should know about?	Y	N	

Does the patient have any difficulty with or history of any of the following: PLEASE CHECK IF YES.

_____AIDS/HIV	_____Diabetes	_____Hearing	_____Nervous Disorders
_____Anemia	_____Endocrine Problems	_____Heart Disease	_____Rheumatic Fever
_____Asthma or Hay Fever	_____Epilepsy	_____Heart Murmur	_____Thyroid
_____Bleeding Disorders	_____Fainting or Dizziness	_____Hepatitis or Liver Disease	_____Tuberculosis
_____Chronic Sinus	_____Glaucoma	_____Kidney	_____Vision
_____Convulsion	_____Headaches	_____Learning Disability	_____Other_____

I acknowledge all of the information given is to the best of my knowledge.

Patient Signature:_____

Patients in active treatment: Please initialize if there is no change in your medical history:
One-year update:_____Date:_____
Two-year update:_____Date:_____