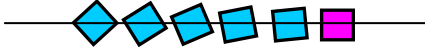


Kenneth A. Shimizu, DDS, MSD



Orthodontic Specialist for Children and Adults

Please fill out this form for your Child as completely as possible prior to your Initial Orthodontic Examination Appointment

About Your Child

Today's Date _____

Child's Name _____ Male Female

He/She prefers to be called _____ Birthdate _____ Age _____

School _____ Grade _____ Hobbies _____

Whom may we Thank for referring your child to our office? _____

Other family members seen by us _____

Is your child concerned about the appearance and health of his/her teeth? _____

Does your child want his/her teeth straightened? _____

Who will be financially responsible for your child's treatment? _____

Parent's Information

Single Married Divorced Widowed Separated

If divorced or separated, who has primary custody? Mother Father

Father's name _____ Please Circle: Mr Dr

Home address _____ Apt. # _____

_____ Years at this address _____

Employer _____ Years Employed _____ Occupation _____

Home # _____ Work # _____ e-mail _____

Soc. Sec. # _____ Driver's License # _____ Birthdate _____

Mother's name _____ Please Circle: Mrs Ms Dr

Home address _____ Apt. # _____

_____ Years at this address _____

Employer _____ Years Employed _____ Occupation _____

Home # _____ Work # _____ e-mail _____

Soc. Sec. # _____ Driver's License # _____ Birthdate _____

Orthodontic Insurance

Is Orthodontic Coverage Available? Yes No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Is Secondary or Dual Insurance Coverage Available? Yes No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Medical Information

Physician's Name _____ Date of Last Medical Exam _____

Address _____ Phone # _____

If currently under a Physician's care, for what reasons? _____

If taking any medications, please list: _____

Is your child allergic to any medications: _____ Latex allergy? _____

Are any medications required prior to dental work? _____

Does your child have or has he/she ever had any of the following: (check if "Yes")

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Tuberculosis / Lung disease | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis / Liver Problems | <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hearing disability |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Learning disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Communication disorder | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Growth disorders |

If Yes, please explain _____

Does your child's growth rate appear to be: Slow Average Fast

Father's height _____ Mother's height _____ Is this child adopted? Yes No

Female patients: Has menstrual cycle started? Yes No At what age? _____

Male patients: Has voice changed? Yes No At what age? _____

Dental Information

Current Dentist's Name _____ City _____ Date of Last Visit _____

Date of Last X-Rays _____ Type _____ Any current dental pain? _____

Has your child had or does he/she experience any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to hot, cold, sweets or pressure | <input type="checkbox"/> Clicking or popping of jaw joint | <input type="checkbox"/> Pain, swelling, or bleeding gums |
| <input type="checkbox"/> Traumatic injury to teeth or mouth | <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Loosening of Permanent teeth |
| <input type="checkbox"/> Pain or tenderness around ear, joint, or side of face | <input type="checkbox"/> Periodontal treatment | Oral habits: <input type="checkbox"/> Thumb or finger sucking |
| Difficulty in: <input type="checkbox"/> Opening / closing <input type="checkbox"/> Chewing | <input type="checkbox"/> TMJ / Splint treatment | <input type="checkbox"/> Lip / Cheek biting <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Swallowing <input type="checkbox"/> Speaking | <input type="checkbox"/> Ulcers / Cold sores | <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Tongue thrust |

If Yes, please explain _____

Has your child ever had an upsetting experience in the dental office? _____

Orthodontic Information

What is your primary concern about your child's teeth? _____

How would you like us to correct the problem? _____

Do you have any concerns about orthodontic treatment? _____

Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____

Please describe _____

Have other family members had orthodontic treatment? _____ Orthodontist _____

Is there any additional information you would like us to know? _____

Please bring this completed form to your Initial Orthodontic Exam Appointment. We look forward to meeting you!

Signed _____ Date _____ Reviewed by _____

The information provided above may be used to obtain Insurance confirmation