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Orthodontic Specialist for Children and Adults

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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 # _____

Please continue

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")

☐ Heart Disease	☐ Ulcers	☐ Epilepsy	☐ Allergies
☐ Abnormal Blood Pressure	☐ Tuberculosis / Lung disease	☐ Frequent Headaches	☐ Sinus trouble
☐ Rheumatic Fever	☐ Venereal Disease	☐ Nervous Disorders	☐ Hay fever
☐ Asthma	☐ Hepatitis / Liver Problems	☐ Cancer or Leukemia	☐ Herpes
☐ Arthritis	☐ Glaucoma	☐ Radiation Therapy	☐ Hearing disability
☐ Bleeding Problems	☐ Diabetes	☐ H.I.V. Positive	☐ Learning disorder
☐ Anemia	☐ Communication disorder	☐ Bone Disorders	☐ 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?

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