

**PATIENT INFORMATION  
CHILD**

DATE \_\_\_\_\_

PATIENT'S NAME(First, Middle, Last): \_\_\_\_\_

Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Name \_\_\_\_\_ Grade \_\_\_\_\_

Siblings \_\_\_\_\_

**Patient Lives With: Father Mother Step-father Step-mother Other**

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's Employer \_\_\_\_\_ Mother's Employer \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

Father's Address \_\_\_\_\_ Mother's Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Other: Step-father Step-mother Grandfather Grandmother Aunt Uncle Guardian**

Name \_\_\_\_\_ Name \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE \_\_\_\_\_

DENTIST NAME & ADDRESS \_\_\_\_\_

Date of Last Check Up and Cleaning \_\_\_\_\_

IMMEDIATE ORTHODONTIC CONCERN OR PROBLEM \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DENTAL INSURANCE COVERAGE**

Insured Name: \_\_\_\_\_ Pt relation to Insured: Self/Spouse/Child/Other

Address (If different than above) \_\_\_\_\_

S/S No. \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Plan Name (if different than Employer): \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group No: \_\_\_\_\_

Address of Ins. Co: \_\_\_\_\_

Telephone No. \_\_\_\_\_

**EMERGENCY INFORMATION:**

Name of nearest relative not living with you \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

**HEALTH QUESTIONNAIRE**

NAME & ADDRESS OF PHYSICIAN \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING: INDICATE WITH AN "X"

- |   |   |
|---|---|
| <input type="checkbox"/> TEETH SENSITIVE TO COLD, HEAT,<br>SWEETS OR PRESSURE | <input type="checkbox"/> ORTHODONTIC TREATMENT  |
| <input type="checkbox"/> BLEEDING GUMS HOW LONG _____                         | <input type="checkbox"/> MOUTH BREATHING  |
| <input type="checkbox"/> FOOD IMPACTION                                       | <input type="checkbox"/> ORAL HABITS, I.E., FINGERNAIL BITING,<br>CHEEK BITING, ETC.  |
| <input type="checkbox"/> CLENCHING OR GRINDING                                | <input type="checkbox"/> CIGARETTES, PIPE OR CIGAR SMOKING                            |
| <input type="checkbox"/> BURNING OF TONGUE                                    | <input type="checkbox"/> FREQUENT BRUSHING  |
| <input type="checkbox"/> SWELLING OR LUMPS IN MOUTH                           | <input type="checkbox"/> DENTAL FLOSS   |
| <input type="checkbox"/> PAIN AROUND EAR                                      | <input type="checkbox"/> WATER JET DEVICE   |
| <input type="checkbox"/> UNUSUAL SOUNDS IN EAR WHEN EATING                    | <input type="checkbox"/> FLUORIDE SUPPLEMENTS   |
| <input type="checkbox"/> BAD BREATH   | <input type="checkbox"/> THUMBSUCKING   |
| <input type="checkbox"/> UNPLEASANT TASTE                                     | <input type="checkbox"/> TONGUE THRUST  |
| <input type="checkbox"/> UNFAVORABLE DENTAL EXPERIENCE                        | <input type="checkbox"/> DO YOU PLAY A MUSICAL INSTRUMENT?<br>IF SO, WHAT KIND? _____ |
| <input type="checkbox"/> COMPLICATIONS FROM EXTRACTIONS                       |   |
| <input type="checkbox"/> PERIODONTAL TREATMENT                                |   |

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL PROCEDURES: YES NO UNSURE

**MEDICAL HISTORY**

- |  |   |
|--|---|
| <input type="checkbox"/> ALLERGIES TO DRUGS<br>(IF SO, WHAT _____) | <input type="checkbox"/> KIDNEY PROBLEMS                          |
| <input type="checkbox"/> ALLERGIES TO ANESTHETICS                  | <input type="checkbox"/> LIVER PROBLEMS OR HEPATITIS              |
| <input type="checkbox"/> ANY HEART AILMENTS                        | <input type="checkbox"/> PSYCHIATRIC CARE / EMOTIONAL PROBLEMS    |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                       | <input type="checkbox"/> RHEUMATIC FEVER                          |
| <input type="checkbox"/> SEIZURES                                  | <input type="checkbox"/> MITRAL VALVE PROLAPSE                    |
| <input type="checkbox"/> NEUROLOGICAL PROBLEMS                     | <input type="checkbox"/> JOINT REPLACEMENT                        |
| <input type="checkbox"/> LEARNING DISABILITIES                     | <input type="checkbox"/> SINUS PROBLEMS                           |
| <input type="checkbox"/> RADIATION TREATMENTS                      | <input type="checkbox"/> IMMUNE SYSTEM DISORDERS (AIDS, HIV, ARC) |
| <input type="checkbox"/> MALIGNANCIES                              | <input type="checkbox"/> STROKE                                   |
| <input type="checkbox"/> EXCESSIVE BLEEDING FROM CUT / EXTRACTION  | <input type="checkbox"/> EYE DISORDERS                            |
| <input type="checkbox"/> ANEMIA OR BLOOD PROBLEMS                  | <input type="checkbox"/> TONSILITIS                               |
| <input type="checkbox"/> THYROID                                   | <input type="checkbox"/> TUBERCULOSIS                             |
| <input type="checkbox"/> ARTHRITIS                                 | <input type="checkbox"/> PREGNANT (IF SO, WHAT MONTH? _____)      |
| <input type="checkbox"/> ASTHMA                                    | <input type="checkbox"/> VENERAL DISEASE                          |
| <input type="checkbox"/> HAY FEVER OR ALLERGIES IN GENERAL         | <input type="checkbox"/> INJURIES TO MOUTH/JAW AREA               |
| <input type="checkbox"/> DIABETES                                  | <input type="checkbox"/> OTHER _____                              |

DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING ANY MEDICATIONS NOT MENTIONED ABOVE:  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF RESPONSIBLE PARTY** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

**DATE:** \_\_\_\_\_