Orthodontics for Children and Adults
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Orthodontics and Dentofacial Orthopedics

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Child's Name_____Date of Birth_____Male___Female____Age_____
Last Dental Visit_____Child's Previous Dentist_____
Purpose of this Visit_____
Who may we thank for referring you to our office _____
Child's School_____Names of Child's Siblings_____

Health History

Child's Physician_____
Is your child adopted? ___No ___Yes If yes, is your child aware?_____
Is your child under a physician's care now?_____Reason_____
Is your child taking any medication or drugs?_____What kind_____Reason_____
Is your child allergic to any medication?_____Please List _____
Does your child have allergic reaction(s) to: food_____animals ____pollen ____dust___latex____other_____
Does your child have any of these habits: finger/thumb habit____pacifier____nail biting____teeth grinding ____
lip sucking____snoring____mouth breathing____nursing bottle ____
Has your child had any injuries to teeth, mouth or head?____Describe_____
Has your child had a history or difficulty with any of the following?

YES NO		YES NO		YES NO		YES NO	
_____	Premature Birth	_____	Delayed Development	_____	Emotional Problems	_____	Nosebleeds
_____	Heart	_____	Motion Sickness	_____	Speech Disorder	_____	Asthma
_____	Seizures	_____	Earaches	_____	Hearing	_____	Liver
_____	Immune Disorder	_____	Kidney	_____	Bone Disorder	_____	Cerebral Palsy
_____	Brain Injury	_____	Rheumatic Fever	_____	Diabetes	_____	Bruising
_____	Fainting or dizziness	_____	Tuberculosis	_____	Hepatitis	_____	Bladder
_____	Anemia	_____	Cancer or Malignancies				

General Information

Parent/Guardian #1_____SSN_____DOB_____
Address_____City_____Zip Code_____
Home Phone_____Cell Phone_____Email_____
Relationship to Patient_____Employer/Occupation_____Work Phone _____
Parent/Guardian #2_____SSN_____DOB_____
Address_____City_____Zip Code_____
Home Phone_____Cell Phone_____Email_____
Relationship to Patient_____Employer/Occupation_____Work Phone _____

Insurance Information

Do you have dental insurance coverage for your child? _____
Name of Insured_____ Name of Insurance Company_____
Group #_____ID#_____Address of Ins. Company _____
IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE BELOW FOR SECONDARY CARRIER;
Name of Insured_____Name of Insurance Company_____
Group #_____ID#_____Address of Ins. Company _____

The permission of parent or guardian is necessary for dental treatment. I give the dentists permission to use such measures as deemed necessary in their professional judgment to render the best dental treatment for my child including the use of anesthetics and medication considered necessary. Parents will be consulted before any treatment is started.

Signature_____Relationship _____Date _____