Welcome!

Thank you for your visit today! We are pleased to welcome you and your child to our practice.
We look forward to working with you to maintain your child's dental health!

Date____

PATIENT INFORMATION

Child's Name____________________________________Nickname________________________________

Date Of Birth_____________ Age_____Gender (*assigned at birth*) Male___Female____ Pronouns ______________

Address____

City/State/Zip____ Phone_________________________

Person Financially Responsible____

Whom may we thank for referring you?____

RESPONSIBLE PARTY INFORMATION

Email address____________________________
Parent/Responsible Name___________________
Relationship to patient______________________
Address_________________________________
____
Home ph.____________Work_______________
Cell____________________________________
Employer________________________________
Employer address________________________
City____________________Zip_____________
SSN____________________DOB______________

Email address___________________________
Parent/Responsible Name________________
Relationship to Patient__________________
Address________________________________
____
Home ph.____________Work____________
Cell___________________________________
Employer______________________________
Employer address______________________
City________________Zip______________
SSN________________DOB______________

DENTAL INSURANCE INFORMATION (Please bring your insurance card with you)

Dental Insurance Primary
Policy Holder/Responsible Party___________________________
Insurance Company Name________________________________
Address____
Phone____
Policy#____
Group#____

Dental Insurance Secondary
Policy Holder/Responsible Party___________________________
Insurance Company Name________________________________
Address____
Phone____
Policy#____
Group#____

Medical History

Now or in the past, has the patient had:

Heart problems Y__ N___

If yes, please specify________________________

Does patient require any medication for dental procedures due to a heart problem? **Y__N__**

If yes, please specify______________________

Birth defects or hereditary problems Y___N___

Bone fractures or major accidents Y___N___

Rheumatoid or arthritic conditions Y ___N___

Endocrine or thyroid problems Y___N___

AIDS or HIV positive Y___N___

Mental health disturbance or behavioral problems Y___N___

Vision, hearing, tasting or speech issues Y___N___

Excessive bruising, anemia or bleeding disorder Y___N___

Frequent headaches, colds or sore throats Y___N___

Eye, ear, nose or throat condition Y___N___

Hayfever, asthma, sinus trouble or hives Y___N___

Tonsil or Adenoid conditions Y___N___

Fainting, seizures or epilepsy Y___N___

Any other significant medical issues:____

____

____

Any family members with significant medical issues:

Allergies:

Please list all drug, Latex and other allergies:_____________________________________

____

____

Is patient taking medication, nutrient supplements, herbal medications, or non prescription medicine?

Please specify_____________________________________

Has patient had any surgeries? Y__N__

If yes, please specify________________________

____

Has patient ever been hospitalized? Y__N__

If yes, please specify________________________

Being treated by another health care professional? Y__N__

Please specify______________________

Pediatrician____

Date of last physical exam_____________________________

Results____

For females:

Has patient started menstruating? Y__N__

At what age__________

Is patient pregnant? Y__N__

Dental History

Dentist____

Date of last exam__________________________________

Results____

Now or in the past, has patient had:

Started teething early or late Y__N__

Primary teeth removed that were not loose Y__N__

Permanent or "extra" teeth removed Y__N__

Congenitally missing teeth Y__N__

Chipped or injured baby or permanent teeth Y__N__

Teeth sensitive to hot or cold Y__N__

Jaw fractures, cysts or mouth infections Y__N__

"Dead teeth" or root canals Y__N__

Bleeding gums, bad taste or mouth odor Y__N__

Periodontal "gum" problems Y__N__

Thumb, finger or sucking habit Y__N__

Abnormal swallowing habit (tongue thrust) Y__N__

Mouth breathing habit, snoring or difficulty breathing Y__N__

Tooth grinding, jaw clenching, clicking or locking Y__N__

Pain in jaw or ringing in ears Y__N__

Pain or soreness in muscles of the face or around the ears Y__N__

Difficulty in chewing or jaw opening Y__N__

Aware of loose, broken or missing fillings Y__N__

Taking any forms of fluoride Y__N__

Any relative with similar tooth or jaw relationships Y__N__

Periodontal "Gum" treatment Y__N__

Has patient had any trouble with previous dental treatment? Y__N__

If yes, please specify_______________________________

____

Ever had a previous orthodontic exam or treatment? Y__N__

If yes, please specify_______________________________

____

Been in another dentist's care Y__N__

Specialist___________________________

Other______________________________

How often does patient brush?_______Floss?_________

What is your primary concern?_____________________________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will also inform this practice. I also acknowledge receipt of privacy practices.

Signature____

Date____