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!

PATIENT INFORMATION

Date_____Home Phone_____

Child's Name_____Nickname_____

Sex Male____ Female___ Pronouns _____ Age_____ Date Of Birth_____

Address_____

City/State/Zip_____

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#_____

See Side 2

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_____