

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 _____ address _____	Email
Parent/Responsible Name _____ Name _____	Parent/Responsible
Relationship to patient _____ Patient _____	Relationship to
Address _____ Address _____ _____	
Home ph. _____ Work _____ ph. _____ Work _____	Home
Cell _____ Cell _____	
Employer _____ Employer _____	
Employer address _____ address _____	Employer
City _____ Zip _____ City _____ Zip _____	
SSN _____ DOB _____ 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 _____