WELCOME TO OUR PRACTICE
FOR CHILDREN

Today's Date: _____

01. Tell Us About Your Child

Preferred Name | ☐ Male ☐ Female | Date of Birth | Age | Child's Home Address

Name (Last | First | Middle) | Apartment Number | City | State | Zip

Home Number | Cell Number | Sibling Name | Age

School | Grade | Sibling Name | Age

Hobbies / Special Interests

02. Who Is With The Child Today?

Name (Last | First | Middle) | Who may we thank for referring you? | Other family members seen by us?

Relationship | Do you have legal custody of this child? ○ Yes ○ No | Previous / Present Dentist | Phone Number | Last Visit

Street

03. Parent Info

Parent 1 Information

Name (Last | First | Middle)

Home Number | Cell Number | Work Number | Employer

Email | SS Number

Parent's Marital Status
○ Single ○ Married ○ Divorced

Parent 2 Information

Name (Last | First | Middle)

Home Number | Cell Number | Work Number | Employer

Email | SS Number

04. Responsible Party Info

Name (Last | First | Middle) | Home Number | Cell Number | Work Number | Employer

Billing Address | Email | SS Number

City | State | Zip

05. Primary Dental Insurance

Insurance Name | Insured's Name (Last | First | Middle)

Insurance Address | Relationship to Patient | Insured's Date of Birth | Insured's Employer | SS Number

City | State | Zip | Orthodontic Coverage? ○ Yes ○ No

Insurance Phone Number | Group / Policy Number

06. Secondary Dental Insurance

Insurance Name | Insured's Name (Last | First | Middle)

Insurance Address | Relationship to Patient | Insured's Date of Birth | Insured's Employer | SS Number

City | State | Zip | Orthodontic Coverage? ○ Yes ○ No

Insurance Phone Number | Group / Policy Number

07. Dental History

Why did you bring this child to the Orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work?
○ Yes ○ No

Is the child taking fluoridated supplements?
○ Yes ○ No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
○ Yes ○ No

Does the child brush their teeth daily?
○ Yes ○ No

Floss their teeth daily?
○ Yes ○ No

Is the child currently under the care of a physician? *
○ Yes ○ No

Explain *

How many times per day do you brush? * | Phone Number * | Last Visit *

Please describe the child's health
○ Good ○ Fair ○ Poor

Please list all the drugs the child is currently taking

Please list all drugs the child is allergic to

* fill the fields if the answer is "Yes" on previous question.

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08. Health History

Do you have a personal physician? *
○ Yes ○ No

Name * (Last | First | Middle)

Are you currently under the care of a doctor? *
○ Yes ○ No

Explain *

Your current physical health is:
○ Good ○ Fair ○ Poor

Phone Number *

Last Visit *

Are you taking any prescription drugs? *
○ Yes ○ No

List *

09. Does The Child Have Any Of The Following Habits?

- ☐ Abnormal Bleeding
- ☐ Allergies to Any Drugs
- ☐ Any Operations
- ☐ Any Stays in Hospital
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Handicaps / Disabilities
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ History of Scarlet Fever
- ☐ HIV+/AIDS
- ☐ Kidney/Liver Problems
- ☐ Prosthesis
- ☐ Rheumatic Fever
- ☐ Tuberculosis

Please discuss any serious medical problems that the child has had

☐ No Health History Concerns

10. Does The Child Have Any Of The Following Habits?

Are you allergic to any of the following?

- ☐ Lip sucking/Biting
- ☐ Nail Biting
- ☐ Nursing Bottle Habits
- ☐ Thumb sucking/Finger Sucking
- ☐ Tetracycline
- ☐ No Allergies

11. Signature

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

☐ I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Date

Signature of parent/guardian

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initials

Date

Doctor's Comments

Medical History Update

Date

Signature

Comments

Date

Signature

Comments

* - fill the fields if the answer is "Yes" on previous question.