

# WELCOME

## 1. TELL US ABOUT YOUR CHILD DATE \_\_\_\_\_

Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_  Male  Female  
Email address \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security# \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Hobbies \_\_\_\_\_

## 2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name \_\_\_\_\_ Relation \_\_\_\_\_ Do you have legal custody of this child?  Yes  No  
Please list brothers / sisters with ages? \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_ General Dentist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Parents Marital Status:  Single  Married  Divorced  Partnered  Separated  Widowed

## 3. PARENTS INFORMATION

**Parent / Guardian 1** Relation \_\_\_\_\_  
Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security# \_\_\_\_\_  
Employer \_\_\_\_\_ How long at current job? \_\_\_\_\_ Occupation \_\_\_\_\_  
Work phone# \_\_\_\_\_ Home phone# \_\_\_\_\_

**Parent / Guardian 2** Relation \_\_\_\_\_  
Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security# \_\_\_\_\_  
Employer \_\_\_\_\_ How long at current job? \_\_\_\_\_ Occupation \_\_\_\_\_  
Work phone# \_\_\_\_\_ Home phone# \_\_\_\_\_

## 4. INSURANCE INFORMATION

### Primary

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Address of Insured \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Secondary

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

## 5. MEDICAL HISTORY

What treatment goals would you like to accomplish? \_\_\_\_\_

Has your child ever been evaluated by an orthodontist?  Yes  No

Has your child ever experienced TMJ pain?  Yes  No

Has your child been informed of missing or extra permanent teeth?  Yes  No

Has your child ever taken Phen-Fen?  Yes  No

Has your child ever taken Fosomax or any other bisphosphonate?  Yes  No

Have adenoids or tonsils been removed?  Yes  No

Has your child ever injured his/her mouth, chin or teeth?  Yes  No

Does your child brush his/her teeth daily?  Yes  No

Does your child floss his/her teeth daily?  Yes  No

Is your child currently under the care of a physician?  Yes  No Please explain: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Is your child currently taking any medication? Please list each one: \_\_\_\_\_

Is your child allergic to:  Latex  Plastics / Metals  Aspirin  Penicillin ? Other \_\_\_\_\_

Has your child ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Asthma	Y N Hemophilia
Y N ADD / ADHD	Y N Cancer	Y N Hepatitis
Y N Allergies to any Drugs	Y N Congenital Heart Defect	Y N HIV+ / AIDS
Y N Allergies to Latex / Metals	Y N Convulsions / Epilepsy	Y N Kidney / Liver Disease
Y N Allergies to Plastic	Y N Diabetes	Y N Rheumatic / Scarlet Fever
Y N Any Hospital Stays	Y N Handicaps / Disabilities	Y N Sinus Problems / Difficulty Breathing
Y N Any Operations	Y N Hearing Impairments	Y N Tuberculosis (TB)
Y N Artificial Bones / Joints / Valves	Y N Heart Murmur	

Please discuss any medical problems that your child has had: \_\_\_\_\_

## 6. HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Clenching / Grinding Teeth	Y N Nail Biting	Y N Finger / Thumb Sucking
Y N Lip Sucking / Biting	Y N Nursing Bottle Habit	Y N Tongue Thrusting
Y N Mouth Breathing	Y N Speech Problems	

I understand that the information given is correct to the best of my knowledge. I also understand that where appropriate, a credit report may be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_