**Tell us about your child:** **Today's Date:** ____________________

Child's Name: ________________________________________________________Gender: ________
Last First MI

DOB: __________________________________ Home Tel# ____________________________________

Child's Home Address: ______________________________________________________________
Street Town Zip

**Who is with the child today/Responsible Party:**

Name: _____________________Relation: __________ Email: _____________________@___________

Whom may we thank for referring you? _____________________________________________________

Other family members seen by us? _________________________________________________________

General Dentist: __________________________________________ Last Visit: _____________________
Name Phone Number

**Parents Marital Status:** Single Married Divorced Widowed

**Parent/Guardian Information:**
Name: __________________________________ Cell: ____________________________

**Parent/Guardian Information:**
Name: ___________________________________ Cell: ____________________________

## Dental Insurance

**Dental Insurance Company:** ________________________**Employer:** _____________________________
**Insurance Company Address:** ______________________________________________________________
**Subscriber Name:** _________________________**Subscriber Date of Birth:** ________________________
**Subscriber ID Number:** ______________________**Group Number:** ______________________________
**Relation to Patient:** ______________________ **Orthodontic Coverage:** *Yes* *No*

**Dental Insurance Company:** _______________________**Employer:** _____________________________
**Insurance Company Address:** ______________________________________________________________
**Subscriber Name:** __________________________ **Subscriber Date of Birth:** _______________________
**Subscriber ID Number:** ______________________**Group Number:** ______________________________
**Relation to Patient:** ______________________ **Orthodontic Coverage:** *Yes* *No*

*Please complete other side*

**Why are you seeking orthodontic treatment for your child?** ________________________________

Has the child ever had serious/difficult problem associated with dental work? Y N

Is the child's water fluoridated? Y/N Is the child taking fluoride supplements? Y N

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Does the child brush daily? Y/N Child's Physician: ________________________________

Tel#: ____________________ Last Visit: ________________________________

Please describe the child's health: Good Fair Poor

Please list all drugs the child is currently taking: ________________________________

Please list any allergies including food and drug: ________________________________

**HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?**

| | | | | | |
|---|---|---|---|---|---|
| Heart Murmur | Y | N | Congenital Heart Def. | Y | N |
| Cancer | Y | N | Convulsions/Epilepsy | Y | N |
| Diabetes | Y | N | Abnormal Bleeding | Y | N |
| Rheum. Fev. | Y | N | Hearing Impairment | Y | N |
| HIV+/AIDS | Y | N | Any Operations | Y | N |
| Hemophilia | Y | N | Any Stays in Hospital | Y | N |
| Asthma | Y | N | Kidney/Liver Problems | Y | N |
| Hepatitis | Y | N | Handicaps/Disabilities | Y | N |
| Tuberculosis | Y | N | Allergies to any drugs | Y | N |
| Prothesis | Y | N | History of Scarlet Fever | Y | N |

Please discuss any serious medical problems that the child has had:

________________________________________________________________

**Does the child have any of the following habits?**

| | | | | | |
|---|---|---|---|---|---|
| Thumb/Finger Sucking | Y | N | Lip Sucking/Biting | Y | N |
| Nail Biting | Y | N | Nursing Bottle Habits | Y | N |

I understand the information I have given is correct to the best of my knowledge, that it will be held in strict confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need during treatment.

________________________________________________________________

Signature of Parent/Guardian Date