We would like to welcome you and your child to our office. Please take the time to fill out this information sheet to help us with your appointment.

Today's Date ____________

Patient Information

Child's Name ____
FIRST MI LAST NICKNAME

Birth date ____/____/_____ Age ___________ _____ Male _____ Female

Address _________________________________City ____________________Zip Code __________

Home Phone (____) _________________ Cell Phone (____) ___________________

School _________________________________Grade _________________

Hobbies or Sports _________________________ Email Address: ____________________________________

Siblings ____

Who may we thank for referring you? ____

General Dentist ____________________________ Location _____________________________

Who is Accompanying Child Today? ____

Parents Information

Mother's Name ____________________________Phone Number_______________________________

Address *(If different from child)*____

City____ Zip Code___________________________

Email Address: ____

Birth date ____/____/____Social Security _____-_____-_____Employer __________________________________

Job Title ________________________________Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Father's Name ____________________________Phone number________________________________

Address *(If different from child)*____

City____ Zip Code___________________________

Email Address: ____

Birth date ____/____/____Social Security _____-_____-_____Employer __________________________________

Job Title ________________________________Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Orthodontic Insurance

Insurance Co. Name ____

Claims Address ____

Phone Number (_____) _________________ Group Number ____________________________

Policy Holders Name ____

Birth date _____/_______/________ Social Security ______-_______-________

Relation to Patient _________________ Employer _____________________________________

What are the main concerns that you would like Orthodontic Treatment to accomplish?

	YES or No
Has your child ever been evaluated for Orthodontic Treatment before?	______
Have there been any injuries to the face, mouth, chin, or teeth?	______
List any musical instruments played ____	
Have adenoids or tonsils been removed?	______
Has your child been advised of any missing or extra permanent teeth?	______
Does your child brush his/her teeth daily?	______
Floss Daily?	______
Has puberty begun?	______

Child's Physician ____

Date of last exam _______________________________ Phone ___________________________

Please list all medications/supplements that your child is taking:

____

Please list any drugs that your child is allergic to:

____

Does your child have an allergy to any of the following?

YES or NO

Latex ______ **Metals/Nickel** ______ **Plastics** ______

<u>Has your child ever had any of the following medical problems?</u>

	YES or NO
Abnormal Bleeding	______
ADD/ADHD	______
Any Hospital Stays?	______
Any Operations?	______
Artificial Bones/ Joints/ Valves	______
Asthma	______
Cancer	______
Congenital Heart Defect	______
Convulsions/ Epilepsy	______
Diabetes	______
Handicaps/ Disabilities	______
Hearing Impairment	______
Heart Murmur	______
Hemophilia	______
Hepatitis	______
HIV+/ AIDS	______
Kidney / Liver Disease	______
Lupus	______
Rheumatic/ Scarlet Fever	______
Tuberculosis	______

If yes to any of the above please explain:

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be my responsibility to inform this office of any changes to my child's medical history. If this office accepts insurance, I understand that I am responsible for payment of services rendered and <u>am also responsible for paying any co-payment or any unpaid balance by the insurance company.</u>

____

Signature of parent or guardian **Date**