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 _____

Other family members we have treated _____

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 _____

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

	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 am also responsible for paying any co-payment or any unpaid balance by the insurance company.

_____

Signature of parent or guardian **Date**