Patient Information: Child (17 & under)

Name: _____ Nickname: _____

Address: _____

Birthdate: _____ Sex: ○ M ○ F

Dentist: _____ Date of last cleaning: _____

How did you hear about us? _____

School name: _____

Does your child have any siblings? ○ Y ○ N Ages: _____

PRIMARY RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Address (if different from above): _____

How long at this address? _____ Home phone: _____ Cell phone: _____

Work phone: _____ Employer: _____ Years of employment: _____

Email: _____ Social Security: _____ Birthdate: _____

Insurance company name: _____

Insurance address: _____

Insurance phone: _____ Group name: _____

Insurance ID#: _____ Group ID#: _____

SECONDARY RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Address (if different from above): _____

How long at this address: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Employer: _____ Years of employment: _____

Email: _____ Social Security: _____ Birthdate: _____

Insurance company name: _____

Insurance address: _____

Insurance phone: _____ Group name: _____

Insurance ID#: _____ Group ID#: _____

(continued...)

Glynda R. McConville, DDS, PA
SANDHILLS ORTHODONTICS

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p: 919.718.9188 fax: 919.718.0900
1129 Carthage Street Sanford, NC 27330

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GENERAL

Describe the primary concern with your child's teeth? _____

○ Y ○ N Has your child had any prior orthodontic consultation or treatment?

What is your child's attitude toward treatment? ○ wants ○ unwilling but agrees ○ doesn't want

What is your child's school performance? ○ above average ○ average ○ slow learner

DENTAL

○ Y ○ N Does your child require antibiotics for dental cleanings?

○ Y ○ N Are you aware that any dental work needs to be completed (ie: fillings)?

○ Y ○ N Is your child presently in any dental pain?

○ Y ○ N Has your child ever had trauma to the head, face or teeth? (if yes, please circle answer)

○ Y ○ N Does your child have any extra, missing or extracted teeth? (if yes, please circle answer)

○ Y ○ N Has your child ever had an unfavorable reaction to dentistry?

○ Y ○ N Does your child have TMJ problems (clicking/pain)?

○ Y ○ N Do any family members have a similar bite?

○ Y ○ N Has your child's adenoids/tonsils been removed?

○ Y ○ N Does your child brush daily?

○ Y ○ N Does your child have any gum problems?

○ Y ○ N Does your child clench/grind the teeth?

○ Y ○ N Does your child have speech problems?

○ Y ○ N Floss daily?

○ Y ○ N Have a finger/thumb habit?

○ Y ○ N Have difficulty chewing?

○ Y ○ N Use any tobacco products?

MEDICAL

Please check any problems or conditions that may apply to your child:

○ Abnormal bleeding/Hemophilia
○ Anemia
○ Asthma
○ Bone disorder
○ Diabetes
○ Drug/alcohol use
○ Endocrine
○ Epilepsy
○ Gastrointestinal
○ Heart problem/defect
○ Heart murmur
○ Hepatitis/Liver
○ Herpes/Fever blisters
○ HIV/AIDS
○ Kidney
○ Psychological/ADD/ADHD
○ Rheumatic/Scarlet fever
○ Tuberculosis
○ Tumor/Cancer
○ Other _____

Age puberty began: _____ Females: Is your child pregnant? ○ Y ○ N Week: _____

Does your child have allergies to any medications or any other substance? _____

List all medications currently being taken: _____

I have read and understand the above questions, and this office's privacy policies. I will not hold Sandhills Orthodontics responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes.

I understand, where appropriate, credit bureau reports may be obtained.

_____ _____

Responsible party signature Date