

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)

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 Floss daily?

Y N Does your child have any gum problems?

Y N Have a finger/thumb habit?

Y N Does your child clench/grind the teeth?

Y N Have difficulty chewing?

Y N Does your child have speech problems?

Y N Use any tobacco products?

MEDICAL

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

Abnormal bleeding/Hemophilia

Epilepsy

Kidney

Anemia

Gastrointestinal

Psychological/ADD/ADHD

Asthma

Heart problem/defect

Rheumatic/Scarlet fever

Bone disorder

Heart murmur

Tuberculosis

Diabetes

Hepatitis/Liver

Tumor/Cancer

Drug/alcohol use

Herpes/Fever blisters

Other _____

Endocrine

HIV/AIDS

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