

# 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: \_\_\_\_\_

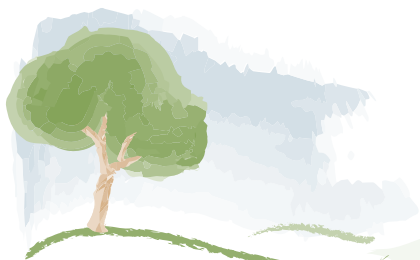
Email: \_\_\_\_\_ Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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