



CHILD NEW PATIENT FORM

First Name: _____ Last Name: _____ Nick Name (if preferred) _____
 Date of Birth: ____ - ____ - ____ Age _____ Female Male School Attending: _____
 Home Address: _____ Parent's Email: _____
 Home Phone #: _____ Cell Phone #: _____
 In Case of Emergency, who should we contact? Name: _____ Phone #: _____
 Who may we thank for referring you? _____
 Other family members seen by us: _____

Mother's Information Primary contact for scheduling? Yes No Financially responsible party? Yes No

First Name: _____ Last Name: _____ Child reside with Mother? Yes No
 Address: (if different from child) _____
 Home Phone #: _____ Cell #: _____ SS #: _____
 Driver License #: _____ State: _____ Employer: _____
 Employer Address: _____
 Work Phone #: _____ Ext. _____ May we call at work? Yes No Best time to call: _____
 Other Phone #: _____ Email: _____

Father's Information Primary contact for scheduling? Yes No Financially responsible party? Yes No

First Name: _____ Last Name: _____ Child reside with Father? Yes No
 Address: (if different from child) _____
 Home Phone #: _____ Cell #: _____ SS #: _____
 Driver License #: _____ State: _____ Employer: _____
 Employer Address: _____
 Work Phone #: _____ Ext. _____ May we call at work? Yes No Best time to call: _____
 Other Phone #: _____ Email: _____

INSURANCE INFORMATION

Members Name: (First) _____ (Last) _____
 Member ID # (SS#): _____ Date of Birth: _____
 Relation to Patient: Mother Father Other Other (explain): _____
 Insurance Carrier: _____ Insurance Phone: () _____
 Insurance Address: _____
 Group, Plan or Policy #: _____ Employer: _____

>>> Please advise us if you have Secondary Orthodontic Insurance <<<

ALTERNATE BILLING (please fill out this section if individuals listed above are not financially responsible)

Person(s) Responsible for Account: _____ Relation to Child: _____
 Home Phone: () _____ Work Phone: () _____ Ext: _____
 Billing Address: _____
 SS #: ____ - ____ - ____ Driver License #: _____ State: _____ Employer: _____
 Employer Address: _____

Our office reserves the right to verify the credit status of potential patients and/or financially responsible parties of potential patients prior to extending credit for treatment fees and may, at our discretion, use one or more credit reporting agencies. I understand I am responsible for payment of services rendered. If my insurance is accepted, I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize this office to submit insurance billing on my behalf with assignment of benefits made to this office, for services rendered. I understand the information I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence, and it is my responsibility to update this office of any changes contained herein.

Parent Signature: _____ **Date:** _____
Parent Name: _____

MEDICAL HISTORY FORM - CHILD

Child's Name: _____ DOB: _____ - _____ - _____ Age: _____
Name of General Dentist: **Dr.** _____ Address: _____
Dentist Phone: (_____) _____ Date of your child's last dental cleaning? _____
What is your child's attitude towards dentists? (ex: fearful, shy, looks forward to...) _____
Name(s) and age(s) sibling(s): _____

Medical History for Child

Yes No Currently under the care of a physician? Name: _____ Address: _____
Please explain: _____
 Yes No Currently taking any medications? *Please list:* _____
 Yes No Allergic to aspirin, codeine, anesthetic, amoxicillin/penicillin, erythromycin, sulfa drugs, latex, nickel or any other medications?
Please list: _____
 Yes No Ever had any serious medical condition, illness, or hospitalization? *Please explain:* _____

If female, are you? Pregnant Nursing Taking birth control pills

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

<input type="checkbox"/> Yes <input type="checkbox"/> No Heart defects / problems / surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Blood disorders, excessive bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer / chemo / radiation tx
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial valve / joint	<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Bone disorders
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Blood transfusion / organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis
<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic / scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No Nervous system problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack / angina / stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells, seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Liver problems, hepatitis
<input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Recurrent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers, Colitis
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Lung problems, difficult breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Sexually transmitted disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma, emphysema, bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Fever blisters, herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Immune disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Drug / alcohol abuse
<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems, hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV+ / AIDS	

Dental History for Child

<input type="checkbox"/> Yes <input type="checkbox"/> No Unhappy with the appearance of his/her teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty in opening or closing the jaws
<input type="checkbox"/> Yes <input type="checkbox"/> No Is your child against wearing braces?	<input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping of the jaw
<input type="checkbox"/> Yes <input type="checkbox"/> No Previous orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Pain (jaw joint, ear, side of face)
<i>If so, with whom:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Missing or extra permanent teeth
<input type="checkbox"/> Yes <input type="checkbox"/> No Consulted an orthodontist before?	<input type="checkbox"/> Yes <input type="checkbox"/> No Tonsil and adenoids removed
<i>If so, with whom:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Biting / chewing habit (circle): toothpick, shirt, gum, ice, pen, pencil, fingernail, thumb, finger, lip, straw
<input type="checkbox"/> Yes <input type="checkbox"/> No Has dentist recommended treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Smoke tobacco
<input type="checkbox"/> Yes <input type="checkbox"/> No Have any family members had treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Play a musical instrument
<input type="checkbox"/> Siblings <input type="checkbox"/> Parents	<input type="checkbox"/> Yes <input type="checkbox"/> No Play active sports
<input type="checkbox"/> Yes <input type="checkbox"/> No Mouth breathing while awake or asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No Still growing in height?
<input type="checkbox"/> Yes <input type="checkbox"/> No Speech problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Still increasing in shoe size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Excessive cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No Has your child reached puberty?
<input type="checkbox"/> Yes <input type="checkbox"/> No Excessive trapping of food between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Girls: Has she started menstruating? Age: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Chipping of front teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Boys: Has his voice changed?
<input type="checkbox"/> Yes <input type="checkbox"/> No Grinding or wear on teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Growth rate relative to others: Average / Slow / Fast
<input type="checkbox"/> Yes <input type="checkbox"/> No Injuries to the face, mouth, or teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Height of Child: _____ Dad _____ Mom _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty brushing or flossing	
<input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty biting or chewing	

I understand that the information that I have provided is correct to the best of my knowledge. I will inform this office of any changes to my child's medical and dental health. I consent to the performing of oral examinations and other necessary dental services for my child by the dental staff. This office is HIPAA, OSHA, CDC and ADA Compliant and are committed to upholding and exceeding the standards set by these entities.

Parent Signature: _____ Parent Name: _____ Date: _____

For Office Use Only: _____

Medical Hx Reviewed by: _____ Date: _____