

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

Has your child ever been evaluated for or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No

Does your child brush his / her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Child's Physician: _____

Phone #: () _____ Date of Last Visit: _____

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Please describe your child's current physical health:
 Good Fair Poor

Please list all drugs that your child is currently taking:

Please list all drugs that your child is allergic to:

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|-------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Diabetes |
| Y N Allergies to any Drugs | Y N Handicaps / Disabilities |
| Y N Allergy to Latex / Metals | Y N Hearing Impairment |
| Y N Allergy to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Asthma | Y N HIV+ / AIDS |
| Y N Cancer | Y N Kidney / Liver Problems |
| Y N Congenital Heart Defect | Y N Rheumatic / Scarlet Fever |
| Y N Convulsions / Epilepsy | Y N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

- | | |
|--------------------------------|----------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Phone: () _____

Address: _____

CITY _____ STATE _____ ZIP _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date _____

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of parent or guardian _____ Date _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of parent or guardian _____ Date _____

The Parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____
