FOR CHILDREN: WELCOME TO OUR PRACTICE

		100m cm		
Today's date:		DOB:		
Child's Name:	Ag	e:		
Last	First			Middle
Preferred Name:		Male		Female
School:		Grade:		
Home#:		Cell#:		
Email:		SS#:		
Hobbies / Special Interest	ts:	-		
Child's Home Addres	55:			
				Apt#:
Siblings:	lity	Stat	e	Zip
Name:		Age:		
Name:		Age:		
2. WH0	O IS WITH THE	CHILD TO	DAY?	
Name:				
Relation:				
Do you have legal custody	y of this child?	Yes	No	
Who may we thank for ret	ferring you?			
Other family members see	en by us:			
Previous/Present Dentist:				

Street:		
Phone #:		Last Visit:
Parent's Marital :	Status:	
(Single, Married,	, Divorced)	
	3. MOTHE	R'S INFORMATION
Name:		Cell#:
WK#:		Home#:
Employer:		
SS#:		

Name: WK#: Employer: SS#:

4. FATHER'S INFORMATION			
	Cell#:		
	Home#:		

5. RESPONSIBLE PARTY INFO			
Name:			
Billing addr	ess :		
	City	State	Zip
WK#:		Home#:	
Cell#:			
Email:			
Employer:			
SS#:			

6. PRIMARY DENTAL INSURANCE			
Ins. Name:			
Ins. address :			
Insurance Co. Phone #:			
Group/Policy # :			
Insured's Name:			
Relationship to Patient:			
Insured's DOB:			
Insured's Employer:			
SS#:			
Orthodontic Coverage	Yes No		

7. SECONDARY DENTAL INSURANCE				
Ins. Name:				
Ins. address :				
Insurance Co. Phone #:				
Group/Policy # :				
Insured's Name:				
Relationship to Patient:				
Insured's DOB:				
Insured's Employer:				
SS#:				
Orthodontic Coverage Yes No				

8. DENTAL HISTORY	9. HEALTH HISTORY			Y	
Why did you bring this child to the Orthodontist today? :		Yes	No Heart Murmur	Yes	No Congenital Heart Def.
			Cancer		Convulsions/Epilepsy
Has the child ever had a serious/difficult problem associated with dental work?			Diabetes		Abnormal Bleeding
Has the child ever had a serious/difficult problem associated with dental work?			Rheumatic Fever		Hearing Impairment
Is the child's water fluoridated?			HIV+/AIDS		Any Operations
Is the child taking fluoridated supplements? Yes No			Hemophilia		Any Stays in Hospital
Has the child ever had any pain or tenderness in			Asthma		Kidney/Liver Problems
the jaw joint (TMJ/TMD)?			Hepatitis		Handicaps/Disabilities
Does the child brush teeth daily? Yes No			Tuberculosis		Allergies to Any Drugs
Floss their teeth daily? 🗌 Yes 📄 No			Prosthesis		History of Scarlet Fever
Is the child currently under the care of a physician? Yes No		Please di	scuss any serious medica	I problems that the	child has had:
Explain:					
Child's Physician:	I	10 00			
Phone #: Last Visit:	ne #: Last Visit: 10. DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?				
Please describe the child's health: Good Fair Poor			Thumb sucking / Finger		Nail Biting
Please list all drugs the child is currently taking:			Lip sucking / biting		Nursing Bottle Habits
Please list all drugs the child is allergic to: Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.				-	
11. I understand the information that I have given is correct to the best of responsibility to inform this office of any changes in my child 's medical sta		owledge	e, that it will be held in	the strictest confi	idence, and it is my
Signature of parent/guardian Date:					
OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY					
I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.		Medic	al History Update:		
Initials: Date:		1. Dat	e:Sign	ature:	
		Comm	ents:		
Doctor 's comments:			e:Sign		
		Comm	ients:		