Dr. Lisa Kochis
ORTHODONTICS

Today's Date:_____

PATIENT INFORMATION

Name: _____ Nickname: _____ Sex:
Address: _____ City, State, Zip: _____ Date of Birth: _____ Age: ___
Home Phone: _____ Child's Dentist: _____ Last Visit: _____
School Attending: _____ Hobbies/Interests: _____
Whom may we thank for this referral? _____

RESPONSIBLE PARTY INFORMATION

Parent's marital status: Single ○ Married ○ Widowed ○ Divorced ○ Separated ○

MOTHER ○ STEPMOTHER ○ GUARDIAN ○ (Relative/Foster) ○
Name:_____ Date of Birth: _____/_____/_____
Address:_____
Work #:_____ Cell Phone #:_____ Home #:_____
Employer:_____ SS#:_____

FATHER ○ STEPFATHER ○ GUARDIAN ○ (Relative/Foster) ○
Name:_____ Date of Birth:_____/_____/_____
Address:_____
Work #:_____ Cell Phone #:_____ Home #:_____
Employer:_____ SS#:_____

Which Party is Financially Responsible?_____
Is there a Financial Split? YES ○ NO ○ If yes, please write down Percentages:_____
Who is the Primary Party who brings your child to appointments?_____

Insurance Company:_____ Orthodontic coverage? Yes ○ No ○
Policy Owner:_____ Group Number:_____
Employer:_____ Claim Address:_____

MEDICAL HISTORY INFORMATION

Child's Physician:_____ Last visit date:_____
Is your child currently under the care of a physician? 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?

Yes ○ No ○ Abnormal bleeding	Yes ○ No ○ Hearing Impairment	Yes ○ No ○ Rheumatic/Scarlet Fever
Yes ○ No ○ Allergies to any Drugs	Yes ○ No ○ Heart Murmur	Yes ○ No ○ Diabetes
Yes ○ No ○ Hepatitis	Yes ○ No ○ Tuberculosis (TB)	Yes ○ No ○ Congenital/Heart Defect
Yes ○ No ○ Hives/Skin Rash	Yes ○ No ○ Asthma	Yes ○ No ○ Handicaps/Disabilities
Yes ○ No ○ HIV+/AIDS	Yes ○ No ○ Convulsions/Epilepsy	Yes ○ No ○ Any Operations, If Yes,
Yes ○ No ○ Exposed to HIV, but Neg.	Yes ○ No ○ Latex Allergy	Please Explain:_____

To help our office provide the best care possible for your child, please disclose any Social or Behavioral Concerns or Syndromes (Autism, Tourette, Bipolar, ADD, ADHD, ODD):_____
Please discuss any serious medical problems your child has had:_____
_____
Does/did your child have any of the following habits? Yes ○ No ○ Lip sucking/ biting
Yes ○ No ○ Thumb/ Finger sucking
What is your chief orthodontic concern?

GROWTH INFORMATION (for evaluation of your child's future growth pattern)

Father's Height_____ Mother's Height_____ Adopted? Yes ○ No ○
Patient Resembles: Neither Parent ○ Mother ○ Father ○
Females: Has she started menstruation? No ○ Yes ○ When?_____ Boys: Has his voice changed? No ○ Yes ○ When?_____
Names and Ages of Patient's Brothers_____
Names and Ages of Patient's Sisters_____