



Today's Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____ Sex: M or F
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: _____ SS#: _____
Work #: _____ Cell Phone #: _____ Home #: _____
Employer: _____ Email: _____
FATHER _____ STEPFATHER _____ GUARDIAN _____ (Relative/Foster) _____
Name: _____ Date of Birth: _____ / _____ / _____
Address: _____ SS#: _____
Work #: _____ Cell Phone #: _____ Home #: _____
Employer: _____ Email: _____
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: _____
Yes _____ No _____ Any Tobacco Use
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 _____