Dr. Lisa Kochis ORTHODONTICS

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____ Allergies to any Drugs
Yes____ No____ Hepatitis
Yes____ No____ Hives/Skin Rash
Yes____ No____ HIV+/AIDS
Yes____ No____ Exposed to HIV, but Neg.
Yes____ No____ Any Tobacco Use
Yes____ No____ Hearing Impairment
Yes____ No____ Heart Murmur
Yes____ No____ Tuberculosis (TB)
Yes____ No____ Asthma
Yes____ No____ Convulsions/Epilepsy
Yes____ No____ Latex Allergy
Yes____ No____ Rheumatic/Scarlet Fever
Yes____ No____ Diabetes
Yes____ No____ Congenital/Heart Defect
Yes____ No____ Handicaps/Disabilities
Yes____ No____ Any Operations, If Yes, 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_____