

# WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

## Patient Information

Name \_\_\_\_\_ Sex ▼  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_  
999-999-9999

Who may we thank for referring you to our office \_\_\_\_\_

## Parents Information

### Father

Name \_\_\_\_\_ Domestic Part ▼  
Last First Middle Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
School \_\_\_\_\_ Brothers/Sisters (include ages) \_\_\_\_\_

Hobbies

## Medical History

Medical Physician? \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Is the child currently under the care of a physician?  Yes  No If Yes, explain \_\_\_\_\_

Has puberty begun?  Yes  No Has menstruation (period) begun?  Yes  No  N/A

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has the patient ever been evaluated for orthodontic treatment? \_\_\_\_\_

Has the patient tonsils or adenoids been removed?  Yes  No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)?  Yes  No

Does the patient have any missing or extra permanent teeth?  Yes  No

Has the patient ever had an injury to : (select all that apply)  Teeth  Mouth  Chin

Does/Has the patient ever had any of the following habits?  Lip Sucking/Biting  Nail biting  Prolonged Bottle/Pacifier  
 Clenching/Grinding Teeth  Mouth Breather  Tongue Thrusting  Thumb/ Finger Sucking

Does the patient have speech problems?  Yes  No If Yes, explain \_\_\_\_\_

### Is the child allergic to any of the following?

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Codeine             | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Tetracycline        | <input type="checkbox"/> Latex        |
| <input type="checkbox"/> Any Metals/Plastics |                                       |

Other Allergies/Sensitivites:  
\_\_\_\_\_

### List all drugs the Patient is currently taking

### List any serious medical condition(s) treated

## Signature

I understand that the information that I have provided 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 hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.  
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_