



Child Patient Information

Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone # where child resides: \_\_\_\_\_ Email: \_\_\_\_\_  
School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent's Name(s): \_\_\_\_\_  
Parent's Cell Phone#(s) \_\_\_\_\_  
Patient lives with: (Circle One)  
Mom Dad Mom & Step-Dad Dad & Step-Mom Grandparent(s) Legal Guardian  
Child's general dentist: \_\_\_\_\_ Last Cleaning Date: \_\_\_\_\_

Responsible Party/Adult Patient Information

Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ If married, spouse's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Home Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_  
Work Phone#: \_\_\_\_\_ Employer: \_\_\_\_\_  
Birthday: \_\_\_\_\_ SS#: \_\_\_\_\_  
Family Dentist: \_\_\_\_\_ Last Cleaning Date: \_\_\_\_\_

Dental Insurance Information

No Dental/Orthodontic Insurance (check box)

Primary Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance phone#: \_\_\_\_\_

DO YOU HAVE DUAL COVERAGE?

If yes:  
Insured's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance phone#: \_\_\_\_\_

PLEASE TURN OVER AND COMPLETE OTHER SIDE!

## MEDICAL HISTORY

Yes No Currently being treated by physician? Reason \_\_\_\_\_  
Yes No Currently taking medication? Reason \_\_\_\_\_  
Yes No Allergies? List: \_\_\_\_\_  
Yes No Allergic to Nickel?  
Yes No Allergic to Latex?  
Yes No Is there any past or current medical condition that we should be aware of?  
Explain: \_\_\_\_\_

Please select if Patient HAS or HAD any of the following:

Asthma Tonsils Removed? Age: \_\_\_\_\_ Adenoids Removed? Age: \_\_\_\_\_

Mouthbreathing: \_\_\_\_\_

## DENTAL HISTORY

Yes No Has the patient had any severe head or face injuries?  
Explain: \_\_\_\_\_

Yes No Has the patient had a history of thumb habit or finger habit?  
Stopped? \_\_\_\_\_ When? \_\_\_\_\_

Yes No Does the patient play any musical (wind) instruments?  
What? \_\_\_\_\_

Yes No Has the patient consulted an orthodontist previously?  
If Yes, who was the orthodontist? \_\_\_\_\_  
When? \_\_\_\_\_

Yes No Have any siblings had orthodontic treatment? \_\_\_\_\_  
If Yes, who was their orthodontist? \_\_\_\_\_  
When did they have treatment? \_\_\_\_\_

Yes No Did either parent have orthodontic treatment?

Please select if there is a history of:

Clenching/grinding teeth      Jaw Joint Clicking/popping      Headaches (more than normal)

Jaw Joint Soreness      Ringing in the ears      Muscular soreness around  
head and neck

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_