

Please complete this form and bring it to your new patient appointment.

## **WE LOOK FORWARD TO YOUR VISIT!**

Name of Minor/Child:	PATIENT INFORMATION											
School and Grade:  Home Address: City/State/ZIP	Name of Minor/Child:	Preferred Nam	e:	Today's Date:								
Home Address: City/State/ZIP Employer: Work Phone: Hobbies: Whom may we thank for referring you:  FAMILY INFORMATION  Father's name:  Mother's Name: DOB: S.S. # DOB: Home Address: (if different from patient) Employer: Work Phone: E-mail: Please list other family members treated here:	SEX: □ Male □ Female		Date of Birth:	Date of Birth:								
City/State/ZIP		Age:										
Employer: Hobbies: Whom may we thank for referring you:  FAMILY INFORMATION  Father's name: DOB:  S.S.#  DOB:  S.S.#  Home Address: (if different from patient)  Employer: Work Phone: Employer: Work Phone: E-mail: Please list other family members treated here:  DENTAL/ALLERGY HISTORY  Date of patient last dental visit: Purpose of last visit: What are the main concerns that you would like orthodontics to accomplish?  Has your child been evaluated for orthodontics treatment before? Has your Child had any injuries to the face, mouth or chin? Has your Child had any pain/tenderness in his/her jaw joint (TMI/TMD)? Does your child brush his/her teeth daily? Does your child play any musical instruments that involve the mouth? Has your Child had any Clenching/Grinding Teeth problems: Speech Problems PAIL INFORMATION General Dentist:  General Dentist:  General Dentist:  FAMILY INFORMATION  Mother's Name:  DOB: S.S.#  Home Address: (if different from patient) Employer: (if differ	Home Address:	Home Phone:										
Hobbies:  Whom may we thank for referring you:  FAMILY INFORMATION  Father's name:  DOB:  S.S. #  DOB:  S.S. #  Home Address: (if different from patient)  Employer:  Work Phone:  E-mail: Please list other family members treated here:  DENTAL/ALLERGY HISTORY  Date of patient last dental visit:  What are the main concerns that you would like orthodontics to accomplish?  Has your child been evaluated for orthodontics treatment before?  Has your Child had any injuries to the face, mouth or chin?  Has your Child been informed of any missing or extra permanent teeth?  Has your Child been informed of any missing or extra permanent teeth?  Has your Child been informed of any missing or extra permanent teeth?  Has your Child been informed of any missing or extra permanent teeth?  Does your child brush his/her teeth daily?  Does your child floss his/her teeth daily?  Does your child play any musical instruments that involve the mouth?  Has your child had any Clenching/Grinding Teeth  Up Sucking/Biting  Yes No  Mouth Breather  Yes No  Nail Biting  Yes No  Tongue Thrust  Pes No  Allergies:  Aspirin Pes No  Codeine Pes No  Dental Anesthetics Pes No	-											
FAMILY INFORMATION												
Father's name:  DOB:  S.S. #  Home Address: (if different from patient)  Employer:  Work Phone:  E-mail: Please list other family members treated here:  DENTAL/ALLERGY HISTORY  Date of patient last dental visit:  What are the main concerns that you would like orthodontics to accomplish?  Has your child been evaluated for orthodontics treatment before?  Has your Child had any injuries to the face, mouth or chin?  Has your Child had any pain/tenderness in his/her jaw joint (TMJ/TMD)?  Does your child floss his/her teeth daily?  Does your child pay any musical instruments that involve the mouth?  Has your child pay any musical instruments that involve the mouth?  Has your child had any clenching/Grinding Teeth Uip Sucking/Biting Pes No Nail Biting Pes No Nail Biting Pes No Tongue Thrust Pes No Allergies:  Aspirin Pes No Codeine Pes No Dental Anesthetics Pes No												
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DOB: S.S.# DOB: S.S.# Home Address: (if different from patient)		FAMILY IN										
Home Address: (if different from patient)  Employer:  Work Phone:  E-mail: Please list other family members treated here:    Dental Allergy History												
(if different from patient)   (if different from patient)		.S. #		S.S #								
Employer:  Work Phone:  E-mail:  Please list other family members treated here:    DENTAL/ALLERGY HISTORY												
Work Phone:  E-mail:  Please list other family members treated here:    DENTAL/ALLERGY HISTORY			1 1 1 1 1	patient)								
E-mail:  Please list other family members treated here:    Date of patient last dental visit:	· · ·											
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Date of patient last dental visit:  What are the main concerns that you would like orthodontics to accomplish?  Has your child been evaluated for orthodontics treatment before?   Yes   No   Has your Child had any injuries to the face, mouth or chin?   Yes   No   Has your Child been informed of any missing or extra permanent teeth?   Yes   No   Has your Child had any pain/tenderness in his/her jaw joint (TMJ/TMD)?   Yes   No   Does your child brush his/her teeth daily?   Yes   No   Does your child floss his/her teeth daily?   Yes   No   Does your child play any musical instruments that involve the mouth?   Yes   No   Has your child had any   Clenching/Grinding Teeth   Yes   No   Mouth Breather   Yes   No   problems:   Speech Problems   Yes   No   Tongue Thrust   Yes   No   Thumb/Finger sucking   Yes   No   Dental Anesthetics   Yes   No	Please list other family members	s treated here:										
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Has your Child had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	, , ,	<u> </u>	anent teeth?									
Does your child brush his/her teeth daily?  Does your child floss his/her teeth daily?  Does your child play any musical instruments that involve the mouth?  Has your child had any of these dental related problems:  Speech Problems  Thumb/Finger sucking  Aspirin   Yes   No   No   No   No   No   No   No   N	· ·	· · · · · · · · · · · · · · · · · · ·										
Does your child play any musical instruments that involve the mouth?  Has your child had any of these dental related problems:  Speech Problems  Thumb/Finger sucking  Aspirin   Yes   No   No   No   No   No   No   No   N	1 1 1			□ Yes □No								
Has your child had any of these dental related problems:    Clenching/Grinding Teeth	Does your child floss his/her teet	th daily?		□ Yes □No								
of these dental related problems:  Speech Problems Thumb/Finger sucking  Aspirin   Yes   No   No   No   No   No   No   No   N	Does your child play any musical	instruments that involve the	ne mouth?	□ Yes □No								
problems: Speech Problems	Has your child had any Clench	hing/Grinding Teeth	□ Yes □No	Mouth Breather	□ Yes □No							
Thumb/Finger sucking	of these dental related Lip Suc	□ Yes □No	_									
Allergies: Aspirin   Yes   No Codeine   Yes   No Dental Anesthetics   Yes   No		□ Yes □No	Tongue Thrust □ Yes □ No									
1	Thumb/Finger sucking		□ Yes □No									
1												
	1											
Does your childLatexYesNoMetalYesNoErythromycinYesNohave any of thesePenicillinYesNoTetracyclineYesNo												
allergies?												
Other Allergies:												
Handicaps/Disabilities:	Handicaps/Disabilities:											

More IMPORTANT details need to be completed on the back of this form. Thank you!

For Office Use ONLY

Patient I.D.#

MEDICAL HISTORY									
Child's Physician: Phone Nu									
Emergency Contact: Phone Nu					Relationship:				
Medical Conditions: Abnormal Bleeding			□Yes	□No	Heart Disease		□Yes □No		
Does your child have or has he/she had any of these		ADD/ADHD		□Yes	□No	Heart Murmur		□Yes □No	
		Anemia/Radiation T	reatment	□Yes	⊐No	Hemophilia		□Yes □No	
		Artificial Bone/Joint	/Valves	□Yes	□No	Hepatitis (□A □B □C)		□Yes □No	
medical conditions?		Arthritis		□Yes	□No	High/Low Blood pressure		□Yes □No	
		Asthma		□Yes	□No	Kidney/Liver Problems		□Yes □No	
		Cancer/Leukemia		□Yes	□No	o Measles/Mumps		□Yes □No	
		Cerebral Palsy		□Yes		Mitral Valve Prolapse		□Yes □No	
		Congenital Heart Defects		□Yes		Mononucleosis		□Yes □No	
		Diabetes		□Yes		Pregnant (currently)		□Yes □No	
		Drug/Alcohol Abuse	!	□Yes		•		□Yes □No	
		Fever Blisters		□Yes		Rheumatic/Scarlet Fever Thyroid Disease		□Yes □No	
		Hearing Impairment Heart Attack/Proble		□Yes □Yes		Tuberculos		□Yes □No	
<b>SI</b>		<u> </u>					15 (16)	Lifes Lino	
Please list any current medications being used by your child and the reason for each:									
		RESPO	NSIBLE P	ARTY INF	ORMA	TION			
Person Financially Responsible:				Date of Birth:					
Relationship to Patie	ent			Social Security Number:					
Home Address:				Home Phone:					
(if Different from pa	tient)				Worl	Phone:			
Employer:				E-Mail:					
		RESPONSIBLE	PARTY II	NSURANCE	INFOR	MATATION			
Do you have orthodo	ntic covera	ge for this minor?	Yes □No	Employe	·:				
Relationship to Patient:			Insured's Name:						
Insurance Company:				Insured's Date of Birth:					
Insurance Claims Address:			Ins. I.D. #						
			Ins. Group #						
Insurance Company Phone:			Social Security # (required):						
Financial	If this office accepts insurance, I understand			that I am This office reserves the right to verify credit of potential					
Information	responsible for payment of service rendered and al			d and also	patients prior to extending credit for treatment fees and				
Signature	responsible for paying any co-payment and/or				may, at the discretion of the office, use the services of one				
Requirement	deductibles that my insurance does not cover.				or more credit reporting services.				
				Circulture of Datient/D					
	Signature of Patient/Responsible Party Date  Lunderstand that the information that I have given is co			Signature of Patient/Responsible Party Date					
Treatment	I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the								
Authorization	strictest of confidence and it is my responsibility to inform this office of any changes in my status. I authorize the								
Signature	dental staff to perform and necessary dental services I may need during diagnostic and treatment.								
Requirement	<u> </u>								
	Signature	of Patient/Responsible	Party				Date		
For Office   I Verb	ally review	ed the medical/dental i	informatio	n above with	the pa	rent/guardia	n and patient named h	erein.	

For Office use ONLY

Doctor's Comments:

Doctor's Initial:

Date: