CHILD INFORMATION FORM

Patient's Name_____ Date of Birth_____ Age_____

School _____Grade_____

Address_____

Phone_____ Email_____

Father's Name_____ Address if Different_____

Father's Occupation_____Employer_____ Phone_____

Mother's Name_____ Address if Different_____

Mother's Occupation_____Employer_____ Phone_____

Who is the Responsible Party? _____

Referred By_____ Have You Seen Another Orthodontist? _____

Patient's Dentist_____ Physician_____

DENTAL INSURANCE

Primary Insurance_____ Policy Holder Name_____ DOB_____ SSN_____

Secondary Insurance _____ Policy Holder Name_____ DOB_____ SSN_____

MEDICAL HISTORY

Significant medical conditions _____

Current medications and reason_____

Allergies_____ Have tonsils or adenoids been removed?_____ What age?_____

Does the patient have a heart murmur or synthetic joint that requires antibiotics before dental work? _____

DENTAL HISTORY

What concerns you about your child's teeth? _____

Other family members with similar orthodontic problems_____

Any injuries to face, mouth, or teeth? _____ Any missing or extra permanent teeth? _____

Has the patient ever been treated for periodontal (gum) disease? _____ Any active dental decay? _____

Does the patient have speech problems? _____

Is the patient a mouth breather? _____ Finger sucking habit? _____ Until what age? _____

Does the patient have a history of TMJ (jaw) clicking, popping, or pain? _____

Signature_____ Date_____

OFFICE USE ONLY: Estimated Fee_____ Treatment Length_____