

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational.

We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child	Person Responsible For Account		
Today's Date: Nickname:CHILD PRIEFERS TO BE CALLED Child's Name:	Name: Relation: Billing Address:		
E-mail Address: SS#:	Previous Address:		
Birthdate: /	CITY STATE 299 Hm # () DL #:		
Hobbies / Sports:	Cell # () SS #: Employer: Wk # () Ext:		
Child's Home Address: AFI/CORDO #	Who is responsible for making appointments? Name: Wk # () Ext: HM #:		
2 Who is Accompanying Your Child Today?	5 Primary Orthodontic Insurance		
Name: Relation:	Orthodontic Coverage? Yes No		
Do you have legal custody of this child? Yes No	Insurance Co. Name:		
Whom may we Thank for referring you?	Insurance Co. Address:		
List brothers / sisters with age:	Insurance Co. Phone #: ()		
	Group # (Plan, Local, or Policy #): Policy Owner's Name:		
General Dentist:	Relationship to Patient:		
Last Visit Date:	Policy Owner's Birthdate: / / ID #:		
Parent's Marital Status: Single Partnered Divorced Widowed	Policy Owner's Employer:		
ACTIVITIES OF ACTIVITIES	Employer's Address:		
3 Mother's Information: Step Mother Guardian	Secondary Orthodontic Insurance		
Name:Birthdate;/	Orthodontic Coverage? Yes No		
Email Address:	Insurance Co. Name:		
Cell #: ()Hm #:()_	Insurance Co. Address:		
Employer: Wk #: () SS #: DL #:	Insurance Co. Phone #: ()		
THE RESERVE OF THE PARTY OF THE	Group # (Plan, Local, or Policy #):		
□ Father's Information: □Step Father □ Guardian Name:	Policy Owner's Name:		
Email Address:	Relationship to Patient:		
Cell #: () Hm #:()	Policy Owner's Employer:		
Employer: Wk #: ()	Employer's Address:		
SS #: DL #:	Employer's Address:		

CONTINUED ON BACK

orthodontics to accomplish?			Has your chi	ld ever had any of the
				medical problems?
Has your child ever taken Phen-Fen?	Yes [No No		
(Also known as Redux or Pondimin) If yes, when?		10	Y N Abnormal Bleeding	Y N Convulsions / Epilepsy
Has your child ever been evaluated or had ort	hodontic		Y N ADD / ADHD Y N Allergies to any Drugs	Y N Diabetes Y N Handicaps / Disabilities
treatment before?	Yes [No S	Y N Allergic to Latex / Metals	Y N Hearing Impairment
Have there been any injuries to the			Y N Allergic to Plastic Y N Any Hospital Stays	Y N Heart Murmur
face, mouth, teeth or chin?	Yes [□ No	Y N Any Hospital Stays Y N Any Operations	Y N Hemophilia Y N Hepatitis
List any musical instruments played:			Y N Artificial Bones / Joints /	Y N HIV+ / AIDS
Have adenoids or tonsils been removed?	Yes [No 🜆	Valves	Y N Kidney / Liver Problems
Has your child been informed of any			Y N Asthma Y N Cancer	Y N Lupus Y N Rheumatic / Scarlet Fever
missing or extra permanent teeth?	Yes [NA BOOK	Y N Congenital Heart Defect	Y N Tuberculosis (TB)
Has your child ever had any pain / tenderne	ess in his /	her		roblems that your child has had:
jaw joint (TMJ / TMD)?	Yes [5.8	riedse discuss any medical pr	obiems that your child has had:
Does your child brush his / her teeth daily?				
Floss his / her teeth daily?	Yes [□ No		
Child's Physician:		1		
Phone #: () Date of La		版		
Is your child currently under the care of a phys			8 Has your cl	
		No No	The second secon	hild ever experienced
Has puberty begun?		No No		f the following?
Has menstruation begun? (Girls)	Yes [No No	Y N Clenching / Grinding Teeth	
Please describe your child's current physical hea		Poor	Y N Lip Sucking / Biting	Y N Speech Problems
Please list all drugs that your child is currently to	10 Page 10 Pag		Y N Mouth Breather	Y N Thumb / Finger Sucking
, , , , , , , , , , , , , , , , , , , ,			Y N Nail Biting	Y N Tongue Thrust
Please list all drugs / things that your child is all	lergic to:		Neighbor or Relative not living w	
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				_Phone ()
Y N Latex Y N Metals/Nickel	Y N Plastic		Address	
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