SHIMIZU ORTHODONTICS

KEVIN M. SHIMIZU, DDS, MSD • KENNETH A. SHIMIZU, DDS, MSD

877 WEST FREMONT AVENUE, SUITE G-1 • SUNNYVALE, CA 94087 • PHONE (408) 738-1314 • SHIMIZUORTHO.COM

Please fill out this form for your Child as completely as possible and email to us prior to your Initial Orthodontic Examination Appointment

ABOUT YOUR CHILD

Today's Date _____

Child's Name _____ ☐ Male ☐ Female

He/She prefers to be called _____ Birthdate _____ Age _____

School _____ Grade _____ Hobbies _____

Whom may we Thank for referring your child to our office? _____

Other family members seen by us _____

Is your child concerned about the appearance and health of his/her teeth?

_____

Does your child want his/her teeth straightened? _____

PARENT'S INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If divorced or separated, who has primary custody? ☐ Mother ☐ Father

Father's name _____ Please Circle: Mr. Dr.

Home address _____ Apt. # _____

_____ Years at this address _____

Employer _____ Years Employed _____ Occupation _____

Soc Sec # _____ Cell # _____ e-mail _____

Driver's License # _____ Birthdate _____

Mother's name _____ Please Circle: Mrs. Ms. Dr.

Home address _____ Apt. # _____

_____ Years at this address _____

Employer _____ Years Employed _____ Occupation _____

Soc Sec # _____ Cell # _____ e-mail _____

Driver's License # _____ Birthdate _____

ORTHODONTIC INSURANCE

Is Orthodontic Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Ins. ID # _____

Is Secondary or Dual Insurance Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Ins. ID # _____

The information provided above may be used to obtain Insurance confirmation

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DENTAL INFORMATION

Current Dentist's Name _____ City _____ Date of Last Visit _____

Date of Last X-Rays _____ Type _____ Any current dental pain? _____

Has your child had or does he/she experience any of the following?

☐ Teeth sensitive to hot, cold, sweets or pressure
☐ Traumatic injury to teeth or mouth
☐ Pain or tenderness around ear, joint, or side of face
Difficulty in: ☐ Opening / closing ☐ Chewing ☐ Swallowing ☐ Speaking
☐ Clicking or popping of jaw joint
☐ Clenching or grinding of teeth
☐ Periodontal treatment
☐ TMJ / Splint treatment
☐ Ulcers / Cold sores
☐ Pain, swelling, or bleeding gums
☐ Loosening of Permanent teeth
Oral habits: ☐ Thumb or finger sucking ☐ Lip / Cheek biting ☐ Nail biting ☐ Mouth breathing ☐ Tongue thrust

If yes, please explain _____

Has your child ever had an upsetting experience in the dental office? _____

MEDICAL INFORMATION

Physician's Name _____ Date of Last Medical Exam _____

Address _____ Phone # _____

If currently under a Physician's care, for what reasons? _____

If taking any medications, please list: _____

Is your child allergic to any medications: _____ Latex allergy? _____

Are any medications required prior to dental work? _____

Does your child have or has he/she ever had any of the following: (check if "Yes")

☐ Heart Disease
☐ Abnormal Blood Pressure
☐ Rheumatic Fever
☐ Asthma
☐ Arthritis
☐ Bleeding Problems
☐ Anemia
☐ Ulcers
☐ Tuberculosis / Lung disease
☐ Venereal Disease
☐ Hepatitis / Liver Problems
☐ Glaucoma
☐ Diabetes
☐ Communication disorder
☐ Epilepsy
☐ Frequent Headaches
☐ Nervous Disorders
☐ Cancer or Leukemia
☐ Radiation Therapy
☐ H.I.V. Positive
☐ Bone Disorders
☐ Allergies
☐ Sinus trouble
☐ Hay fever
☐ Herpes
☐ Hearing disability
☐ Learning disorder
☐ Growth disorders

If yes, please explain _____

Does your child's growth rate appear to be: ☐ Slow ☐ Average ☐ Fast

Father's height _____ Mother's height _____ Is this child adopted? ☐ Yes ☐ No

Female patients: Has menstrual cycle started? ☐ Yes ☐ No At what age? _____

Male patients: Has voice changed? ☐ Yes ☐ No At what age? _____

ORTHODONTIC INFORMATION

What is your primary concern about your child's teeth? _____

How would you like us to correct the problem? _____

Do you have any concerns about orthodontic treatment? _____

Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____

Please describe _____

Have other family members had orthodontic treatment? _____ Orthodontist _____

Is there any additional information you would like us to know? _____

_____

Please email this completed form to info@shimizuortho.com prior to your first appointment.
We look forward to meeting you!

Signed _____ Date _____ Reviewed by _____