NEW PATIENT FORM (CHILD)

How did you hear about us? ______________________________

What is the most important thing you would like for us to fix? ______________________________

Appointment Reminder Preference: ❑ Text ❑ Phone Call ❑ Email (Email Address:)______________________________

Patient Name (First, Middle Initial, Last): ______________________________

Birth Date: ______________ **Age:** __________ **Sex: Male ❑ Female ❑**

S.S.N.: ______________________ **Home Phone No.:** ______________________

Patient's Address: ______________________________

City: ______________________ **State:** __________ **Zip/Postal Code:** __________

No. of brothers and sisters: ______________ **Ages:** ______________________

Other family members treated here: ______________________________

Father's name: ______________________ **Cell Phone:** ______________________

Address: ______________________________

Mother's Name: ______________________ **Cell Phone:** ______________________

Address: ______________________________

Dentist Name: ______________________ **Phone:** ______________________

Address: ______________________________

Physician's name: ______________________ **Phone:** ______________________

Address: ______________________________

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________

Date of Birth: ______________________

Social Security#: ______________________

Employer: ______________________

Work Phone: ______________________

Employer Address: ______________________

City ______________ **State** ______ **Zip** __________

Insurance Company: ______________________

Group #: ______________________

Address: ______________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________

Date of Birth: ______________________

Social Security#: ______________________

Employer: ______________________

Work Phone: ______________________

Employer Address: ______________________

City ______________ **State** ______ **Zip** __________

Insurance Company: ______________________

Group #: ______________________

Address: ______________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: ______________________________

PATIENT PROFILE

- ❑ Yes ❑ No Does patient follow directions well?
- ❑ Yes ❑ No Does patient brush his/her teeth at lease 2 times per day?
- ❑ Yes ❑ No Does patient have learning disabilities or need extra help with instructions?
- ❑ Yes ❑ No Is patient sensitive or self-conscious about teeth?
- ❑ Yes ❑ No Is the patient pregnant?

MEDICAL HISTORY: Now or in the past, has the patient had:

- ❑ Yes ❑ No Birth defects or hereditary problems?
- ❑ Yes ❑ No Bone fractures, any major accidents?
- ❑ Yes ❑ No Rheumatoid or arthritic conditions?
- ❑ Yes ❑ No Endocrine or thyroid problems?
- ❑ Yes ❑ No Kidney problems?
- ❑ Yes ❑ No Diabetes?
- ❑ Yes ❑ No Cancer, tumor, radiation treatment or chemotherapy?
- ❑ Yes ❑ No Stomach ulcer or hyperacidity?
- ❑ Yes ❑ No Polio, mononucleosis, tuberculosis or pneumonia?
- ❑ Yes ❑ No Problems of the immune system?
- ❑ Yes ❑ No AIDS or HIV positive?
- ❑ Yes ❑ No Hepatitis, jaundice or liver problems?
- ❑ Yes ❑ No Fainting spells, seizures, epilepsy or neurological problem?
- ❑ Yes ❑ No Mental health disturbance of behavioral problem?
- ❑ Yes ❑ No Vision, hearing, tasting or speech difficulties?
- ❑ Yes ❑ No Loss of weight recently, poor appetite?
- ❑ Yes ❑ No History of eating disorder (anorexia, bulimia)?
- ❑ Yes ❑ No Bleeding disorder, bruising tendency, excessive bleeding or anemia?
- ❑ Yes ❑ No High or low blood pressure?
- ❑ Yes ❑ No Tires easily?
- ❑ Yes ❑ No Chest pain, shortness of breath or swelling ankles?
- ❑ Yes ❑ No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn hear defects, hear murmur or rheumatic heart disease)?
- ❑ Yes ❑ No Skin disorder?
- ❑ Yes ❑ No Does the patient eat a well-balanced diet?
- ❑ Yes ❑ No Frequent headaches, colds or sore throats?
- ❑ Yes ❑ No Eye, ear, nose or throat condition?
- ❑ Yes ❑ No Hayfever, asthma, sinus trouble or hives.
- ❑ Yes ❑ No Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

- ❑ Yes ❑ No Local anesthetics (Novocaine or Lidocaine)?
- ❑ Yes ❑ No Aspirin?
- ❑ Yes ❑ No Ibuprofen (Motrin, Advil)?
- ❑ Yes ❑ No Penicillin or other antibiotics?
- ❑ Yes ❑ No Sulfa drugs?
- ❑ Yes ❑ No Codeine or narcotics?
- ❑ Yes ❑ No Metals (jewelry, clothing snaps)?
- ❑ Yes ❑ No Latex (gloves, balloons)?
- ❑ Yes ❑ No Vinyl?
- ❑ Yes ❑ No Acrylic?
- ❑ Yes ❑ No Animals?
- ❑ Yes ❑ No Foods (specify)? _______________________
- ❑ Yes ❑ No Other substances (specify)? _____________ _____________________________________

❑ Yes ❑ No Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication: _________________ Taken for: ______________

Medication: _________________ Taken for: ______________

Medication: _________________ Taken for: ______________

- ❑ Yes ❑ No Does the patient currently have or ever had a substance abuse problem
- ❑ Yes ❑ No Does the patient chew or smoke tobacco?
- ❑ Yes ❑ No Operations? (specify) _________________
- ❑ Yes ❑ No Hospitalized? (for) ____________________
- ❑ Yes ❑ No Other physical problem or symptoms? (describe) ___________________________
- ❑ Yes ❑ No Being treated by another health care professional? (for) ____________________
  Date of most recent physical exam: ______
- ❑ Yes ❑ No Are there any other medical conditions that we should be aware of?
  ____

I have read and understand the above questions. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ________________________ Date signed: _________
(Parent or Guardian)

Signed: ________________________ Date signed: _________
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, has the patient had:

- ❑ Yes ❑ No Would patient object to wear orthodontic appliances (braces) should they be indicated?
- ❑ Yes ❑ No Concerns about his/her profile?
- ❑ Yes ❑ No Concerns about spaced, crooked or protruding teeth?
- ❑ Yes ❑ No Aware or concerned about under or over developed jaw?
- ❑ Yes ❑ No Any relative with similar tooth or jaw relationships?
- ❑ Yes ❑ No Have teeth grown in quickly or slowly?
- ❑ Yes ❑ No Primary teeth removed by his/her Dentist?
- ❑ Yes ❑ No Thumb, finger or sucking habit? Until what age? _____________
- ❑ Yes ❑ No Abnormal swallowing or tongue thrust habit?
- ❑ Yes ❑ No History of speech problems?
- ❑ Yes ❑ No Mouth breathing habit, snoring or difficulty in breathing?
- ❑ Yes ❑ No Had periodontal (gum) treatment?

- ❑ Yes ❑ No Permanent or "extra" (supernumerary) teeth removed?
- ❑ Yes ❑ No Chipped teeth or other wise injured teeth?
- ❑ Yes ❑ No Teeth sensitive to hot or cold; throb or ache?
- ❑ Yes ❑ No Jaw fractures, cysts or mouth infections?
- ❑ Yes ❑ No "Dead teeth" or root canals treated?
- ❑ Yes ❑ No Food impactions between teeth?
- ❑ Yes ❑ No Tooth grinding, jaw clenching, clicking or locking?
- ❑ Yes ❑ No Any pain in jaw or ringing in the ears?
- ❑ Yes ❑ No Any pain or soreness in the muscles of the face or around the ears?
- ❑ Yes ❑ No Difficulty in chewing or jaw opening?
- ❑ Yes ❑ No Any loose, broken or missing fillings?
- ❑ Yes ❑ No "Gum Boils" canker sores, or cold sores?
- ❑ Yes ❑ No Taking any forms of fluoride?
- ❑ Yes ❑ No Any serious trouble associated with any previous dental treatment?

❑ Yes ❑ No **Has the patient ever had an orthodontic examination or received orthodontic treatment before?**

Doctor's name: ___________________________________ Date of Exam/Treatment: ________________________

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Signed: ____ Date signed: ____________
(Parent or Guardian)

Signed: ____ Date signed: ____________
(Dental Staff Member)