GENERAL INFORMATION

Cell phone _____

Child's residence _____ Home phone _____

Please give the address and home phone for both parents even if they are divorced or separated.

Mother's Name _____	Father's Name _____
Home Address _____	Home Address _____
_____	_____
Home Phone _____	Home Phone _____
Cell phone _____	Cell phone _____
Email _____	Email _____
Birthdate _____	Birthdate _____
Social Security No. _____	Social Security No. _____
Place of Employment _____	Place of Employment _____
Position _____ Phone _____	Position _____ Phone _____
Dental Insurance _____	Dental Insurance _____
Orthodontic Coverage NO YES Amount _____	Orthodontic Coverage NO YES Amount _____

Are there special arrangements regarding billing of these procedures? _____

_____

What is your preferred method of contact? □ Home # □ Cell # □ Email □ Text

Please print contact information _____

Please provide information regarding additional insurance coverage provided, such as step parents, etc.

I understand that the information that I have given on the Dental and Medical history for and the information given to the Doctor are correct and complete to the best of my knowledge, and that it is my responsibility to inform the Doctor of any change in my child's medical or dental status.

Date _____ Signature _____

Child' Name _____ Nickname _____

Date of Birth _____ Sex ____Male ____Female Age ____

Reason for this appointment _____

DENTAL HISTORY

(Please circle the appropriate answer)

Any previous orthodontic treatment? NO YES

Any baby teeth or permanent teeth removed by a dentist? NO YES

Any major falls or accidents involving the head, face or teeth? NO YES

Any difficulty breathing through the nose awake or asleep? NO YES

Any clenching of teeth or grinding teeth at night? NO YES

Have other members of your family had orthodontic treatment? NO YES

Does anyone else in your family have similar dental problems? NO YES

Number of brothers _____ Ages ( ) ( ) ( ) ( ) ( )

Number of sisters _____ Ages ( ) ( ) ( ) ( ) ( )

Child's Dentist _____ Date teeth last cleaned _____

HEALTH HISTORY

(Please circle if you have or had any of the following)

Tonsils and/or adenoids removed? NO YES Rheumatic fever? NO YES

Allergies (Including Medications)? NO YES Diabetes? NO YES

Heart Murmur? NO YES

Environmental allergies (such as dogs, cats, trees, etc.)? NO YES

if yes, explain _____

Any Drugs or **NSAIDS** (Advil, Motrin) taken regularly? NO YES

Any other health problems? NO YES If yes, explain _____

Any behavior problems NO YES

Is your child mentally alert? NO YES

Has your child tested positive for HIV or Hepatitis? NO YES

Does your child have ADD, FASD, or any other problems? NO YES

Is your child currently takin Ritalin, Prozac, or others? NO YES

If yes, what is the dosage and how many times a day? _____

If female, has menstruation began? NO YES If yes, at what age? _____

Is your child in good health now? NO YES

Has your child ever had a serious illness or injury? NO YES If yes, explain _____

Child's Physician? _____

Name of School that the child attending _____ Grade attending _____

Does the child play an instrument? NO YES If yes, explain _____

How did you hear about our office? _____

Note: THIS SIDE IS TO BE COMPLETED BY THE DOCTOR

CUSPIDS: Class I II III MOLARS: Class I II III

TEETH:

Retained deciduous

E D C B A A B C D E
E D C B A | A B C D E

Permanent Present

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Permanent Missing

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Crowding
Mx _____ Ma _____

X-Bite _____

Overbite _____ %

Overjet _____ mm

Midline
a) Upper
b) Lower

Tongue Thrust _____

Swallow YES NO

Musculature _____

Oral Hygiene _____

Habits _____

Path of Closure _____

Attitude towards RX _____

Comments _____

Misc. _____

Date _____ RX _____