

Child's New Patient Form



ABOUT YOUR CHILD

Name: _____
Last First MI

Nickname: _____ Male/Female

Birthdate: _____ Age: _____

Home Phone: _____

Home Address: _____

Email: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Brothers & Sisters:

Name	Birthdate
_____	_____
_____	_____
_____	_____

How did you hear about our office?

INSURANCE

Primary Dental Insurance:

Orthodontic Coverage? Yes / No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Group # (Plan, Local or Policy #): _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Birthdate: _____

Policy Holder Employer: _____

Employer's Address: _____

Secondary Dental Insurance:

Orthodontic Coverage? Yes / No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Group # (Plan, Local or Policy #): _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Birthdate: _____

Policy Holder Employer: _____

Employer's Address: _____

PARENT'S INFORMATION

Mothers Information: Mother/Step/Guardian

Name: _____ Birthdate: _____

Hm Phone: _____ Wk Phone: _____

Employer: _____

How long at current job?: _____ Job Title: _____

Father's Information: Father/Step/Guardian

Name: _____ Birthdate: _____

Hm Phone: _____ Wk Phone: _____

Employer: _____

How long at current job?: _____ Job Title: _____

Person Responsible For Account:

Name: _____ Relation: _____

Employer: _____

Hm Phone: _____ Wk Phone: _____

Email: _____

Billing Address: _____

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What are the main concerns you orthodontist to address?

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to your child's face, mouth, teeth or chin? Yes No

Does your child require antibiotics before dental work? Yes No

Have adenoids or tonsils been removed? Yes No

Does your child have any missing or extra permanent teeth? Yes No

Has your child ever had jaw pain/tenderness in the jaw joint (TMJ)? Yes No

Does your child brush their teeth daily? Yes No

Are your child's teeth flossed daily? Yes No

Is your child currently under the care of a physician? Yes No

Physician's Name: _____

Phone Number: _____ Date of last visit: _____

Please describe your child's current physical health:

Good Fair Poor

Please list all drugs your child is currently taking:

Has your child experienced any of the following medical problems?

Y N Abnormal Bleeding Y N Hearing Impairment

Y N ADD/ADHD Y N Heart Murmur

Y N AIDS/HIV+ Y N Hemophilia

Y N Hospital Stays/ Operations Y N Sickle Cell Disease/ Traits

Y N Hepatitis Y N Kidney Problems

Y N Asthma Y N Liver Problems

Y N Cancer Y N Mitral Valve Prolapse

Y N Prosthetics Y N Congenital Heart Defect

Y N Convulsions Y N Rheumatic Fever

Y N Diabetes Y N Scarlet Fever

Y N Epilepsy Y N Tuberculosis (TB)

Y N Artificial Bones/Joints/ Valves Y N Handicaps/Disabilities

Are your child's immunizations current? Yes No

Did/does your child have any of the following habits?

Y N Nursing Bottle Habits Y N Used Pacifier

Y N Speech Problems Y N Lip Sucking/Biting

Y N Mouth Breather Y N Thumb/Finger Sucking

Y N Nail Biting Y N Tongue Thrust

Y N Clenching/Grinding Teeth

Does your child play any musical instruments?: _____

Is your child allergic to any of the following?

Y N Latex Y N Any Metal/Jewelry

Y N Plastic

Please list any other food or drug allergies that your child has:

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the Orthodontist and the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian

Date

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I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

Initials: _____ Date: _____

