

For Office Use Only

Date _____

Acct# _____
Records _____
Consult _____
Banding _____

CHILD

PATIENT INFORMATION

Patient's Name: _____ Nickname: _____
 Street: _____ City: _____ Zip: _____
 Sex: _____ Age: _____ Date of Birth: _____ Home Phone: _____
 Patient's Dentist (first & last name): _____ Physician: _____
 Referred by: _____
 School: _____ Grade: _____ Sports: _____
 E-mail Address: _____ Hobbies: _____
 Reason for seeking treatment: _____

RESPONSIBLE PARTY INFORMATION

Father's Name: _____ Occupation: _____ Work Phone: _____
 Employer: _____ Address: _____ City: _____
 SS#: _____ How long with this employer: _____
 Mother's Name: _____ Occupation: _____ Work Phone: _____
 Employer: _____ Address: _____ City: _____
 SS# _____ How long with this employer: _____
 Parents divorced: _____ Separated: _____ Custodial Parent: _____
 Adult patient lives with, if other than parent: _____ Relationship: _____
 Names and Ages of other children in family: _____
 Responsible for account: _____ Phone: _____
 Responsible party's address: _____ City: _____ State: _____ Zip: _____
 How long at this address: _____ Previous address (if less than 3 years): _____
 Do you have insurance which covers orthodontics: _____ Insurance company name: _____
 Name of Insured: _____ Group#: _____ Insured's Date of Birth: _____

Check any of the following habits that apply to the patient:

Habit	Now	Past	Stopped at age:
Mouth breathing:			
Awake ___ Asleep ___ Both ___			
Snoring:			
Clicking or pain in the jaw joint (by the ears):			
Grinding teeth:			
Awake ___ Asleep ___			
Sucking: Fingers ___			
Thumb ___ Blanket ___			
Swallowing:			
Tongue Thrust ___			
Nail Biting			
Other:			
Current Medication Being Taken:			

Does the patient have or has the patient had:

Condition	Yes	No	?	Condition	Yes	No	?
Rheumatic Fever				Scarlet Fever			
Heart Condition				Whooping Cough			
Diabetes				Swallowing Problem			
Anemia				Breathing Problem			
Epilepsy				Chewing Problem			
Pneumonia				Nervous Condition			
Hepatitis				Glaucoma			
Type				Reaction to drugs			
Asthma				What?			
Tuberculosis/PPD(+)				Fainting			
Speech Problem				Kidney Problem			
Measles				Frequent Colds			
Chickenpox				Freq. ear infections			
Mumps				Other:			
Allergies							
To What?							

"I understand where appropriate, credit bureau reports may be obtained."

PARENT SIGNATURE _____