

Child Patient Form

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Orthodontic Medical and Dental Questionnaire

(Please Complete and Bring to Appointment)

Patient/General Information

Patient's Full Name

Last

First

Middle

Date of Birth

Age

Nickname

Sex M F

Patient's Address (Street)

City

Zip

Patient's Phone

Grade in School

Patient's School

Brothers/Sisters (Names & Birthdates)

Brothers

Sisters

Date of Birth

If yes, please give details.

Does he/she frequently participate in contact sports?

Play a musical instrument?

What are main extracurricular activities or interests?

Patient's Father

Name

Last

First

Middle

Marital Status

Married

Separated

Divorced

Widowed

Residence (if different from patient)

Street

City

State

Zip

How long at this address?

Home Phone

Work Phone

Cell Phone

Previous Address (if less than 1 year)

Street

City

State

Zip

Social Security #

Birthdate

E-mail Address

Occupation

Employer

Of Years Employed

Patient's Mother

Name

Last

First

Middle

Marital Status

Married

Separated

Divorced

Widowed

Residence (if different from patient)

Street

City

State

Zip

How long at this address?

Home Phone

Work Phone

Cell Phone

Previous Address (if less than 1 year)

Street

City

State

Zip

Social Security #

Birthdate

E-mail Address

Occupation

Employer

Of Years Employed

Responsible Party Information (If other than above)

Name

Last

First

Middle

Marital Status

Married

Separated

Divorced

Widowed

Residence

Street

City

State

Zip

How long at this address?

Home Phone

Work Phone

Previous Address (if less than 1 year)

Street

City

State

Zip

Social Security #

Birthdate

Relationship to Patient

Occupation

Employer

Of Years Employed

We offer budgeted payment plans; therefore our office reviews credit bureau information.

Patient Dental History

Patient's Dentist

Phone Number

When was the last dental check up?

Approximate date of last dental X-ray taken

What is patient's orthodontic problem as you see it?

Has the patient been examined by an orthodontist before? If yes, when?

Any blow or injury to the face or teeth?

Any thumb sucking?

Tooth clenching or grinding (at night)?

Other habits?

(Explain)

Any clicking or pain when he/she opens or closes his/her mouth?

Referral Information

Who may we thank for referring you to this office?

Area or address (if available)

Names of close friends or relatives that are patients of this practice

Patient Medical History

Patient's Physician

Phone Number

How is patient's general health?

Is the patient now under a physician's care? If yes, for what reason?

Is the patient taking any medication at present?

Have medical X-rays been taken in the past year?

Does the patient have:

Any difficulty breathing through nose?

Any difficulty in swallowing or chewing?

Diabetes?

Asthma?

Rheumatic Fever?

Convulsions?

Any Contagious Diseases?

Is the patient allergic to anything? (Food, Drugs, Etc.)

Does the patient need to be **premedicated** for any reason?

Are the patient's tonsils and adenoids present?

Insurance Information

Do you have dental insurance? Yes No

Who is the primary insurance carrier? Father Mother Other

Insurance Company

Insurance Address

Street

City

State

Zip

Phone

Group Number

Policy Number

Local Number

Union Number

Claim Number

Signature