WELCOME
TO OUR PRACTICE

ANDREWS ORTHODONTICS
smiles that EMPOWER.

CHILD PATIENT INFORMATION

Patient's Name ______________________ Preferred Name ______________
First Last

Sex ☐ M ☐ F D.O.B ________ Age _____ School ______________________ Grade ________

Hobbies or Interests? ______________________________

Child's Residence ______________________________
Street City Zip

Other family members seen by us? ______________________________

Siblings (ages) ______________________________

PARENTAL MARITAL STATUS (Please choose one) ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

MOTHER'S INFORMATION

Relationship to child (check one) ☐ Mother ☐ Step-Mother ☐ Guardian

Title (check one) ☐ Mrs. ☐ Ms. ☐ Dr.

Name ______________________ Email ______________________
First Last

Cell# ______________ Home# ______________ Work# ______________

Residence ______________________________
Street City Zip

D.O.B ________ Age _____ SS# ______________ Job Title ______________

Employer ______________________ How long at current job? ________

Dental insurance ☐ Y ☐ N

Other family members seen by us? ______________________________

FATHER'S INFORMATION

Relationship to child (check one) ☐ Mother ☐ Step-Mother ☐ Guardian

Title (check one) ☐ Mr. ☐ Dr.

Name ______________________ Email ______________________
First Last

Cell# ______________ Home# ______________ Work# ______________

Residence ______________________________
Street City Zip

D.O.B ________ Age _____ SS# ______________ Job Title ______________

Employer ______________________ How long at current job? ________

Dental insurance ☐ Y ☐ N

Other family members seen by us? ______________________________

CONTINUED ON BACK

DENTAL HISTORY

General Dentist ______________________ Date of last visit ______________

What would you love to change about your child's smile? ______________________

Does your child have (or ever had) any of the following traits?

- ☐ Clenching/Grinding
- ☐ Lip Sucking/Biting
- ☐ Nail Biting
- ☐ Thumb/Finger Sucker
- ☐ Mouth Breather
- ☐ Tongue Thruster
- ☐ Prone To Cavities
- ☐ Bleeding Gums

Have your child ever been evaluated for, or received orthodontic treatment? ☐ Yes ☐ No Date __________

Have your child ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have your child ever had a problem with previous dental work? ☐ Yes ☐ No

Have your child ever broken or chipped any teeth? ☐ Yes ☐ No

Has there ever been any serious injury to the face, mouth, or chin? ☐ Yes ☐ No

Does your child now or ever experience pain or discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Has anyone in your family ever received orthodontic treatment? If yes, where? ______________________

HEALTH HISTORY

Please list all medications your child is currently taking ______________________

Please list all medications/substances that your child is allergic to ______________________

Check any of the following conditions you have (or have had) in the past

- ☐ Autism Spectrum Disorders
- ☐ ADD/ADHD
- ☐ Depression/Anxiety
- ☐ Nervous Disorders
- ☐ Handicap/Disability
- ☐ Other (Please detail below)
- ☐ Heart Murmur/Problems
- ☐ High/Low Blood Pressure
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Asthma/Hay Fever/Sinus Problems
- ☐ Difficulty Breathing
- ☐ Gastro Disorders
- ☐ Arthritis
- ☐ Bone Disorders/Osteoporosis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Herpes/Fever blister
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ HIV/AIDS

Has your child had their tonsils or adenoids removed? ☐ Y ☐ N If yes, what age? ______________

List any serious illness (physical or mental) not mentioned above ______________________

Any medical conditions that we have not discussed that we should be aware of? ☐ Y ☐ N

If yes please explain ______________________

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I have truthfully answered all questions and agree to inform this office of any changes in my medical and dental history. In addition, I authorize the Andrews Orthodontics dream team to perform all necessary dental services that may be needed during diagnosis and treatment with my informed consent.

Signature ______________________ Date______________

DOCTOR NOTES