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) ☐ Father ☐ Step-Father ☐ 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	☐ Nail Biting	☐ Mouth Breather	☐ Prone To Cavities
☐ Lip Sucking/Biting	☐ Thumb/Finger Sucker	☐ Tongue Thruster	☐ 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	☐ Heart Murmur/Problems	☐ Asthma/Hay Fever/Sinus Problems	☐ Diabetes
☐ ADD/ADHD	☐ High/Low Blood Pressure	☐ Difficulty Breathing	☐ Epilepsy
☐ Depression/Anxiety	☐ Abnormal Bleeding	☐ Gastro Disorders	☐ Herpes/Fever blister
☐ Nervous Disorders	☐ Anemia	☐ Arthritis	☐ Kidney Problems
☐ Handicap/Disability	☐ Dizziness	☐ Bone Disorders/Osteoporosis	☐ Hepatitis
☐ Other (Please detail below)	☐ Headaches/Migraines	☐ Congenital Heart Defect	☐ 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 _____
_____

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

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