

WELCOME

TO OUR PRACTICE



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 _____ SS# _____ Job Title _____
Employer _____ How long at current job? _____
Dental insurance with orthodontic coverage 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 _____ SS# _____ Job Title _____
Employer _____ How long at current job? _____
Dental insurance with orthodontic coverage Y N
Other family members seen by us? _____

CONTINUED ON BACK

INSURANCE SUBSCRIBER INFORMATION

SAME AS MOTHER'S INFO SAME AS FATHER'S INFO

Name _____ D.O.B _____ SS# _____
First Last

Residence _____

Employer _____

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?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Clenching/Grinding | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Mouth Breather | <input type="checkbox"/> Prone To Cavities |
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Thumb/Finger Sucker | <input type="checkbox"/> Tongue Thruster | <input type="checkbox"/> Bleeding Gums |

Has your child ever been evaluated for, or received orthodontic treatment? Yes No Date _____

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

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

Has 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

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