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 _____ SS# _____ Job Title _____

Employer _____ How long at current job? _____

Dental insurance with orthodontic coverage ☐ Y ☐ N

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

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?

☐ Clenching/Grinding ☐ Nail Biting ☐ Mouth Breather ☐ Prone To Cavities
☐ Lip Sucking/Biting ☐ Thumb/Finger Sucker ☐ Tongue Thruster ☐ 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? _____

_____

smiles that EMPOWER.

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_____