

**WELCOME TO OUR OFFICE**

**SO THAT WE MIGHT BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING:**

Today's Date \_\_\_\_\_

**CHILD'S NAME:** \_\_\_\_\_ Preferred First Name: \_\_\_\_\_ Sex:  Male  Female

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

**Parents' or Guardians' Information:**

**Father** \_\_\_\_\_ Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Phone \_\_\_\_\_

**Mother** \_\_\_\_\_ Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Present Martial Status of Parents:  Married  Widowed  Separated  Divorced—child lives with \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

If Dental Insurance, Name of Carrier \_\_\_\_\_ Do They Provide Orthodontic Benefits?  Yes  No  Not Sure

Relatives or Friends Treated Here \_\_\_\_\_

**Who referred you, or how did you find out about our office?** \_\_\_\_\_

**Medical History**

Child's Physician \_\_\_\_\_ City \_\_\_\_\_

DOES YOUR CHILD HAVE ANY HISTORY OF THE FOLLOWING:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Asthma or hay fever        | <input type="checkbox"/> Speech Problems    |
| <input type="checkbox"/> Heart disease or murmur | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Behavior Problems  |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Bone disorder           | <input type="checkbox"/> Prolonged bleeding         | <input type="checkbox"/> Slow in Learning   |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Nervous disorders          | <input type="checkbox"/> Other _____        |

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

- Tonsils and/or adenoids been removed?  Yes  No If yes, at what age? \_\_\_\_\_
- Under physician's care at this time? Specify: \_\_\_\_\_
- Taking any medications at this time? Specify: \_\_\_\_\_
- Any allergies? Specify: \_\_\_\_\_
- Ever had an allergic or unfavorable reaction to any drug or medication? Specify: \_\_\_\_\_

TO HELP DETERMINE YOUR CHILD'S GROWTH POTENTIAL: GIRLS: Has she started menstruation (monthly periods)?  Yes  No  
BOYS: Has voice changed?  Yes  No Started to shave?  Yes  No

**Dental History**

Child's Dentist \_\_\_\_\_ City \_\_\_\_\_

Approximate Date of Last Dental Visit \_\_\_\_\_ Reason \_\_\_\_\_

- Injuries or operations to the face, mouth or teeth? \_\_\_\_\_
- Do you know any missing or extra permanent teeth? \_\_\_\_\_

HAVE YOU OBSERVED THAT YOUR CHILD HAS ANY OF THESE HABITS?

- Thumb or finger sucking? \_\_\_\_\_ At this time? \_\_\_\_\_ If stopped, until what age? \_\_\_\_\_  Mouth breathing?  Tongue thrust?

Has your child had previous orthodontic treatment or consultation?  Yes  No Remarks: \_\_\_\_\_

**What is the primary reason you are seeking an orthodontic examination?** \_\_\_\_\_

Signature \_\_\_\_\_

**Thank You**