For Child

Thank you for completing the information below. The information in this history form will help us provide the best care and service.

Patient Information

Patient 's Name_________________________________ Age_______DOB__________

First Middle Last

Nick Name (if preferred)____________________ [ ] M [ ] F SS#______________

Home Address____

City______________________ State_________ Zipcode______________

Person Responsible For Account

Name ___________________________ DOB______ Relationship____________

Billing Address____________________ City/State/Zipcode______________

Home Phone_____________ Work Phone_____________ SS#______________

Cell Phone____________________ Email_________________________

Employer___________________________ Occupation______________

Employer's Address____

Insurance Information

Primary Insurance Company Name_______________ Phone Number_____________

Group Number__________ Policy Number____________

Insured's Name____________ DOB________ Insured's SS#____________

Relationship________ Insured's Employer____________

Employer's Address____

Secondary Insurance Company Name__________ Phone Number_______________

Group Number/Policy Number__________ Insured's Name_________ DOB_________

Insured's SS#_________________________ Relationship_________________

Employer's Address____

Medical History

Physician's Name__________________ Phone Number______________ Date of Last Visit_______________

Address____

Yes No

[ ] [ ] Is the patient taking any pills, medications, or drugs?

[ ] [ ] Does the patient have any allergies or unusual reaction to any medication?

List Medications____

Are there any medical problems we should be aware of?____

Dental History

Dentist's Name____ Phone Number_______________________

Address____

What is the major concern about the patient's teeth?____

Frequency of Dental Checkup/Cleaning____________ Date of Last Checkup/Cleaning______________

Yes No

[ ] [ ] Has the patient had a previous orthodontic consultation or treatment?

[ ] [ ] Has any family member had orthodontic treatment? Who?___________________________

[ ] [ ] Does the patient have any habits, such as thumb sucking, tongue thrusting, mouth-breathing, nail biting?

[ ] [ ] Does the patient have pain or a clicking of the jaw joint?

[ ] [ ] Does the patient grind or clench their teeth?

[ ] [ ] Does the patient ever have pains in the face or head?

[ ] [ ] Has the patient ever had a severe jaw or head injury?

[ ] [ ] Does the patient snore?

Are there any other dental/orthodontic problems we should be aware of?_________________________

How did you hear about us?____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status

I UNDERSTAND THAT WHEN APPROPRIATE CREDIT BUREAU MANY BE OBTAINED FOR FINANCIAL ARRANGEMENT.

Parent/Guardian Signature____ Date___________________