CHILD ORTHODONTIC PATIENT INFORMATION

Date________________________________ Nickname________________________________

Patient's Name________________________________ Adopted? ________________________________

Male____ Female____ Age____ Birthdate__________________ Phone ____________________

Month Day Year

Address____

Street City State Zip

E-mail Address ____

School____ Grade ____________________

General Dentist______________________________ Family Physician ____________________

How did you hear about our office? ____

Main reason(s) for seeking orthodontic treatment ______________________________________

____

Patient's hobby or special interest ____

Father's Name ____

Employed by ______________________________________ Phone ____________________

Mother's Name ____

Employed by ______________________________________ Phone ____________________

NAME OF RESPONSIBLE PARTY FOR ACCOUNT ________________________________

Relationship to the patient ____

Address____

Street City State Zip

No. of years at this address? ______ Previous address (if less than 3 yrs.) ____________________

Work phone ______________________________ Social Security # ____________________

Employed by ______________________ Occupation __________________ No. of Yrs ______________

Is the patient covered by orthodontic insurance? __________ Primary insured's DOB ______________

Primary Insurance Co. ______________________________ Policy No. ____________________

Insurance Co. telephone ____

Secondary Insurance Co. ______________________________ Policy No. ____________________

Insurance Co. telephone ____

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617 BALL STREET | GRAPEVINE, TX 76051 | 817.488.5653 | www.robinsonbraces.com

Medical History

Is the patient in good health? **Yes No** Explain: ______________________

Does the patient have any major or unusual illnesses? **Yes No** Explain: ______________________

Is the patient currently under the care of a physician? **Yes No** Reason: ______________________

Does the patient have any allergies? **Yes No** List: ______________________

Does the patient have any drug sensitivities? **Yes No** List: ______________________

Please indicate if the child has or has ever had any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Anemia	___	___	Heart problems	___	___	Frequent colds or flu
___	___	Blood disease	___	___	Tuberculosis	___	___	Frequent Tonsilitis
___	___	Prolonged bleeding	___	___	Diabetes	___	___	Tonsils removed? Age ________
___	___	Jaundice	___	___	Endocrine disorder	___	___	Adenoids removed? Age_______
___	___	Rheumatic Fever	___	___	Bone disorder	___	___	Asthma
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Mouthbreathing: Awake? _____
___	___	Hepatitis	___	___	Herpes	___	___	Mouthbreathing: Asleep? _____

Dental History

Yes No

___ ___Does the patient see a dentist regularly?

___ ___Has the patient had any severe head or facial injuries? Explain: ______________________

___ ___History of thumb or finger sucking? Has the habit ceased? __________ At what age?__________

___ ___Has the patient consulted with an orthodontist previously?

___ ___Has the patient had any previous orthodontic treatment? Explain: ______________________

___ ___Did either parent have orthodontic treatment? Did the treatment involve jaw surgery? ___________

Does the patient have any siblings? ______ Names and ages: ______________________

______________________Have any of them had orthodontic treatment?________________

Please check if there is a history of:

____ Jaw joint popping _____ Jaw joint clicking ____ Jaw joint pain/soreness _____ Frequent headaches

____Grinding teeth ____ Clenching teeth ____ Ringing in the ears ____ Head or neck muscle soreness

Is there any other info about your child that may be important for us to know? ______________________

____

Who may we thank for referring you to our office? ______________________

Signed: ______________________ Date: ______________________