



Patient Information

Date _____ Age _____ Yrs. _____ Mos. _____ Birthdate _____

Patient's Name _____
Last First Nickname Middle

Address _____
Street City State Zip

Home Phone # _____

Hobbies _____ School _____ Grade _____

General Dentist _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

☐ Father ☐ Step-father ☐ Guardian

Name _____ Financially Responsible ☐ Yes ☐ No
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Mother ☐ Step-mother ☐ Guardian

Name _____ Financially Responsible ☐ Yes ☐ No
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Insurance Information

Insured's Name Last _____ First _____ Relationship _____
Social Security # _____ ID # _____
Employer _____
Insurance Company _____
Birthdate _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Phone _____
Orthodontic Coverage ☐ Yes ☐ No

Additional Coverage

Insured's Name Last _____ First _____ Relationship _____
Social Security # _____ ID # _____
Employer _____
Insurance Company _____
Birthdate _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Phone _____
Orthodontic Coverage ☐ Yes ☐ No

Emergency Information

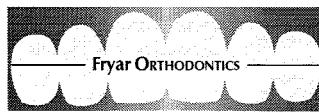
Name of Nearest Relative Not Living With You _____
Relationship to patient _____
Complete Address _____
Phone _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that where appropriate, credit bureau reports may be obtained.

Signature Of Patient Or Parent of Minor _____ Date _____



Child Medical History

Patient's Name _____ Date _____

Is patient in good health? _____ Yes ☐ No ☐

Does patient have any history of major illness? _____ Yes ☐ No ☐

Has patient ever been under the care of a physician for illness? _____ Yes ☐ No ☐

Please list _____

Please explain any pertinent Medical History: _____

Check the following for which patient has been treated:

_____ Glaucoma	_____ Bone disorders	_____ Endocrine Problems
_____ Diabetes	_____ Tuberculosis	_____ Prolonged Bleeding
_____ Pneumonia	_____ Anemia	_____ Fainting or Dizziness
_____ Heart Trouble	_____ Epilepsy	_____ Nervous Disorders
_____ Rheumatic Fever	_____ Asthma	_____ Liver Involvement
_____ HIV Positive / Aids	_____ Kidney Involvement	

Does patient have a tendency to colds? _____ Sore throats? _____ Ear infections? _____

Have tonsils and adenoids been removed? _____ What age? _____

List any allergies or medication now being taken. Give reasons: _____

Has patient reached puberty? _____ Girls: Has she started menstruation Yes ☐ No ☐

Boys: Has his voice changed Yes ☐ No ☐

Height _____ Weight _____ Does patient gag easily? Yes ☐ No ☐

Name and age of Brothers and Sisters: _____

Patient's Dental History

Have there ever been any injuries to the face, mouth or teeth?

yes _____ no _____

Have you ever sucked your fingers or thumb? Until what age?

yes _____ no _____

Do you have any speech problems?

yes _____ no _____

Are you a mouth breather? While awake?

yes _____ no _____

While asleep?

yes _____ no _____

Have you been informed of any missing or extra permanent teeth?

yes _____ no _____

Have you consulted an orthodontist previously?

yes _____ no _____

Did either parent have orthodontic treatment?

yes _____ no _____

Do you have pain in the jaw joints? ☐ Right ☐ Left Do you have popping or cracking of the jaw joint? ☐ Right ☐ Left

When did this begin? _____