Associated Orthodontists EST 1969

FOR CHILDREN: WELCOME TO OUR PRACTICE

Date: _____ OPMS#: _____

Doctor: CY D S P T

Location: J F M P B NL

Exam With: _____

PATIENT INFORMATION

PATIENT NAME: _____ MALE ❑ FEMALE ❑ DOB: _____ AGE: _____

PREFERRED NAME: _____ HOBBIES/SPECIAL INTERESTS: _____

ADDRESS: _____ PHONE: (____)_____CELL: (____)_____

CITY: _____ STATE: _____ ZIP: _____ SCHOOL: _____ GRADE: _____

NAME OF GENERAL DENTIST: _____ PHONE : (_____)_____

NAME OF OTHER FAMILY MEMBERS TREATED AT ASSOCIATED ORTHODONTISTS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FATHER'S INFORMATION

NAME: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

EMPLOYER: _____

MARITAL STATUS:

❑SINGLE ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED ❑DOMESTIC PARTNER

❑ OTHER _____

SPOUSES NAME : _____

MOTHER'S INFORMATION

NAME: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

EMPLOYER: _____

MARITAL STATUS:

❑SINGLE ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED ❑DOMESTIC PARTNER

❑ OTHER _____

SPOUSES NAME : _____

ADDITIONAL RESPONSIBLE PARTY INFORMATION - *IF APPLICABLE* (i.e. stepparent, legal guardian)

NAME: _____ RELATIONSHIP: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____ EMPLOYER: _____

MARITAL STATUS: ❑SINGLE ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED ❑DOMESTIC PARTNER ❑ OTHER _____

___

PLEASE COMPLETE SIDE 2

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____

_____

HAS THE CHILD EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH DENTAL WORK? ___ ❑ YES ❑ NO

HAS YOUR CHILD BEEN SEEN BY AN EAR, NOSE & THROAT (ENT) DOCTOR? _____ ❑ YES ❑ NO

HAVE THE TONSILS/ADENOIDS BEEN REMOVED? _____ ❑ YES ❑ NO

IS THE CHILD'S WATER FLUORIDATED? _____ ❑ YES ❑ NO

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS? _____ ❑ YES ❑ NO

HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? _____ ❑ YES ❑ NO

HAS THE CHILD EVER HAD ANY TRAUMA TO THE MOUTH OR JAW JOINT? _____ ❑ YES ❑ NO

PLEASE DESCRIBE TRAUMA: _____

_____

DOES THE CHILD HAVE A HISTORY OF SPEECH PROBLEMS/SPEECH THERAPY? _____ ❑ YES ❑ NO

DOES THE CHILD HAVE TOOTH SENSITIVITY? _____ ❑ YES ❑ NO

DOES THE CHILD BRUSH TEETH DAILY? _____ ❑ YES ❑ NO

FLOSS THEIR TEETH DAILY? _____ ❑ YES ❑ NO

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? _____ ❑ YES ❑ NO

EXPLAIN: _____

CHILD'S PHYSICIAN: _____

PHONE: (____) _____ LAST VISIT: _____

PLEASE DESCRIBE THE CHILD'S HEALTH: _____ ❑ GOOD ❑ FAIR ❑ POOR

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING: _____

_____

PLEASE LIST ALL DRUGS THE CHILD IS ALLERGIC TO: _____

_____

YES	NO		YES	NO	
❑	❑	HEART MURMUR	❑	❑	ADD OR ADHD
❑	❑	CANCER	❑	❑	CONGENITAL HEART DEFECT
❑	❑	DIABETES	❑	❑	CONVULSIONS/EPILEPSY
❑	❑	RHEUMATIC FEVER	❑	❑	ABNORMAL BLEEDING
❑	❑	HIV+/AIDS	❑	❑	HEARING IMPAIRMENT
❑	❑	HEMOPHILIA	❑	❑	ANY OPERATIONS
❑	❑	ASTHMA	❑	❑	ANY STAYS IN HOSPITAL
❑	❑	HEPATITIS	❑	❑	KIDNEY/LIVER PROBLEMS
❑	❑	TUBERCULOSIS	❑	❑	HANDICAPS/DISABILITIES
❑	❑	PROSTHESIS	❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	ALLERGIC TO LATEX & METAL	❑	❑	HISTORY OF SCARLET FEVER

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT THE CHILD HAS HAD: _____

_____

_____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

THUMB SUCKING / FINGER SUCKING _____ ❑ YES ❑ NO

LIP SUCKING / BITING _____ ❑ YES ❑ NO

MOUTH BREATHING _____ ❑ YES ❑ NO

SNORING _____ ❑ YES ❑ NO

NAIL BITING _____ ❑ YES ❑ NO

NURSING BOTTLE HABITS _____ ❑ YES ❑ NO

ABNORMAL SWALLOWING _____ ❑ YES ❑ NO

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

Signature of parent/guardian _____ Date: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.