

Date: \_\_\_/\_\_\_/\_\_\_



A B C

Allergy Alert

**CHILD PATIENT INFORMATION (UNDER AGE 18)**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  Male  Female  
Nickname/Preferred Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Other children in the household:**

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

**Whom may we thank for referring you to the office?**

My dentist: \_\_\_\_\_ Friend/Family Member: \_\_\_\_\_  
Other: \_\_\_\_\_  
Other Family Members Seen By Us: \_\_\_\_\_  
School Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Sports/Hobbies: \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ins. Co. Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Dual Coverage: Yes or No. If yes, please fill out below:**

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ins. Co. Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

**PARENT INFORMATION**

**Parent #1 Name:** \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Relationship to patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How long? \_\_\_\_\_ Rent or Own? (Circle one)  
Previous address if above is less than 3 years: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN: \_\_\_/\_\_\_/\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ # of years employed: \_\_\_\_\_

**Parent #2 Name:** \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Relationship to patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How long? \_\_\_\_\_ Rent or Own? (Circle one)  
Previous address if above is less than 3 years: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN: \_\_\_/\_\_\_/\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ # of years employed: \_\_\_\_\_  
Marital Status (circle one): Single Married Divorced Widowed Separated Other: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Complete Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Previous Address if above is less than 3 years: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

As the responsible party, I hereby agree to provide payment for all services not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY**

Physician Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
Physician Address: \_\_\_\_\_ Physician Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Please circle yes or no for the following questions and provide additional details as necessary:**

- Yes No Is the patient taking any medication? If so, what? \_\_\_\_\_
- Yes No Is the patient allergic to any medication? Latex? If so, what? \_\_\_\_\_
- Yes No Does the patient have a history of major illness? If so, please describe: \_\_\_\_\_
- Yes No Have seen a physician in the last 12 months? List any reasons other than annual checkup. \_\_\_\_\_
- Yes No Is the patient pregnant? If so, due date: \_\_\_\_\_
- Yes No Has the patient been advised to take antibiotics prior to dental appointments? If so, Why? \_\_\_\_\_

**Please circle any of the medical conditions below that you have had or currently have:**

- |                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver Problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma/Hayfever              | Gastrointestinal Disorders | HIV/Aids                 | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney Problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

Are there any medical conditions not listed above that you feel we should be aware of?  
\_\_\_\_\_

**DENTAL HISTORY**

General Dentist Name: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_ **Has the patient had their teeth cleaned in the last 12 months?** Yes No  
What concerns you most about your teeth? \_\_\_\_\_

**Please circle yes or no for the following questions and provide additional details as necessary:**

- Yes No Is the patient presently in any dental pain? \_\_\_\_\_
- Yes No Has the patient ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Has the patient had wisdom teeth removed? \_\_\_\_\_
- Yes No Has the patient ever lost or chipped any teeth? \_\_\_\_\_
- Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_
- Yes No Is any part of the patient's mouth sensitive to temperature? If so, where? (Upper, lower, left, right, etc...) \_\_\_\_\_
- Yes No Is any part of the patient's mouth sensitive to pressure? If so, where? (Upper, lower, left, right, etc...) \_\_\_\_\_
- Yes No Do the patient's gums bleed when brushing? \_\_\_\_\_
- Yes No Does the patient have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Is the patient a mouth breather? \_\_\_\_\_
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes No What is the patient's attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment? How did they feel about the result? \_\_\_\_\_
- Yes No Do the patient's teeth or jaws ever feel uncomfortable when awakening in the morning? \_\_\_\_\_
- Yes No Is the patient aware of any jaw clicking or popping? \_\_\_\_\_
- Yes No Is the patient aware of any clenching of teeth during the day? \_\_\_\_\_
- Yes No Has the patient ever been told they grind their teeth? \_\_\_\_\_
- Yes No Does the patient have "tension" headaches? \_\_\_\_\_
- Yes No Has the patient ever experienced chronic ringing in your ears? \_\_\_\_\_
- Yes No Does the patient need extra help with instructions? \_\_\_\_\_
- Yes No Is the patient sensitive or self-conscious about his/her teeth?  
Height of biologic parents: Mother \_\_\_\_\_ Father \_\_\_\_\_

Describe any other dental concerns:  
\_\_\_\_\_

**BENEFITS**

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. J. Lawrence Hutta and Dr. Brandon Cook to perform a complete orthodontic evaluation. Please be aware that some appointments will be during school hours.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health history updated:

Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_