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:______________