



CHILD PATIENT INFORMATION

Patient Name _____
Last first Middle

Address _____
Street City Zip Code

School _____

Referred By _____

Dentist _____

Physician _____

Mother's Name _____
Last First Middle

Social Security Number _____

Home Address _____

Phone (____) _____ (____) _____
Home Work or Emergency

Cell Phone (____) _____ Email _____

Employer _____

Work Address _____

Date of Birth _____ M ____ F ____
Month Day Year

Phone (____) _____

Siblings _____

Patient Email _____

Phone (____) _____

Phone (____) _____

Father's Name _____
Last First Middle

Social Security Number _____

Home Address _____

Phone (____) _____ (____) _____
Home Work or Emergency

Cell Phone (____) _____ Email _____

Employer _____

Work Address _____

Is Patient covered by orthodontic insurance? YES NO

If yes, please complete the following information.

IF YOU HAVE COVERAGAE FORM MORE THAN ONE COMPANY, PLASE GIVE ALL INFORMATION FOR EACH COMPANY.

Name of Insurance Company(s) Name of Policyholder(s) Date of Birth

Policyholder's Employer(s) Union Local Number(s) Employer Group Number(s)

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Policyholder's Employer(s) Union Local Number(s) Employer Group Number(s)

Person Responsible for Account _____

Dental History

What is your main concern, reason for seeing orthodontic treatment? _____

Has an orthodontic been consulted previously? _____

Date of last dental care _____

Family history of orthodontic problems _____

Were there any habits which might have caused the teeth to move? (i.e. nail or lip biting, thumbsucking, etc.) _____

	YES	NO	ORAL HYGIENE continued	YES	NO
Has there been any injuries to the face, mouth or teeth?	[]	[]	Has a dentist or hygienist shown patient		
Does the patient have any speech problems?	[]	[]	how to clean his/her teeth?	[]	[]
Are there any missing or extra permanent teeth?	[]	[]	Do you still use these methods?	[]	[]
List any musical instruments played by mouth _____					
Does patient have clenching or grinding habits?	[]	[]	How often does patient brush his/her teeth? _____		
Does the patient have sore or sensitive teeth?	[]	[]	List type toothbrush (hard, med, soft) _____		
Has patient ever had any orthodontic treatment?	[]	[]	List any other aids (i.e. floss, stimudent, water spray		
			Device, rubber tip, toothpick) and how often used ____		

ORAL HYGIENE

Is patient self-conscious about the appearance of his/her teeth? [] []
 Has a dentist or hygienist shown patient how to clean
 his/ her teeth?..... [] []
 Additional general dental information: _____

When was the last professional dental cleaning? ____
 How often scheduled? _____

MEDICAL HISTORY

Date of last medical care _____

Have you been a patient in a hospital in the past 2 years? []Yes []No Reason _____

Health is [] Excellent [] Good [] Fair [] Poor

Do any of the following pertain to you? (Please check and describe fully under remarks.)

	YES	NO		YES	NO
1. Allergies	[]	[]	13. Rheumatic Fever	[]	[]
a. penicillin or other Antibiotics.....	[]	[]	14. Stroke	[]	[]
b. local anesthetic	[]	[]	15. Do you have a pacemaker?	[]	[]
c. Metal	[]	[]	16. High Blood Pressure	[]	[]
d. Latex	[]	[]	17. Low Blood Pressure	[]	[]
e. Other	[]	[]	18. Kidney Disease	[]	[]
2. Arthritis	[]	[]	19. Liver Disease, Hepatitis, Jaundice	[]	[]
3. Asthma	[]	[]	20. Psychiatric Treatment	[]	[]
4. Blood Disease or Abnormal Bleeding Problems []	[]	[]	21. Radiation Treatment	[]	[]
a. Anemia	[]	[]	22. Respiratory Diseases	[]	[]
b. Clotting problems	[]	[]	23. Stomach or Duodenal Ulcers	[]	[]
c.Excessive bleeding requiring treatment	[]	[]	24. Tumor History	[]	[]
d. Other blood disorders	[]	[]	25. Venereal Disease	[]	[]

MEDICAL HISTORY CONTINUED

- | | | | | | |
|---|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| 5. Chest Pains, Ankle Swelling or Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | 26. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 27. A.I.D.S./ HIV + | <input type="checkbox"/> | <input type="checkbox"/> |
| Occurrence in immediate family | <input type="checkbox"/> | <input type="checkbox"/> | 28. Phen-Fen or Diet Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | 29. Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Fainting | <input type="checkbox"/> | <input type="checkbox"/> | 30. Bisphosphonates | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Glandular Disease (thyroid, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | 31. Other Medical Concerns: | _____ | |
| 10. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 11. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 12. Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | YES | NO |
| 28. Is patient taking medicine, drugs or pills regularly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, name medication(s) _____ | | | | |
| 29. Does patient require pre-medication with antibiotics prior to dental treatment (based on physician's instruction)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has patient experienced any unfavorable reaction to previous dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please explain particulars _____ | | | | |
| Please explain any particulars if any "yes" answers were given above: | | | | |
| _____ | | | | |

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first name above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or his nurse or qualified designate.

I authorize assignment of insurance benefits payable to Dr. Law.

Signed _____ Date _____
 Patient, parent or agent (Must be 18 years or older)

There is no change, to my personal knowledge, on my medical history. Medical History Reviewed:

Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____