Child New Patient Form

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant, stress free and educational. We pride ourselves in creating beautiful smiles that lasts a lifetime. We look forward to seeing you in the office.

First Name *

Last Name *

Month of Birth *

Day of Birth *

Year of Birth *

School

Grade

Email address

General Dentist

Date of Last Appointment

Who may we thank for referring you to our office?

Home Address

Street Address

Address Line 2

City

State

Zip Code

Home Phone # *

Cell Phone #

Information must be filled out completely

Custodial Parent Information

Relationship *

Mother Step Mother Guardian Father

Name *

Month of Birth *

Day of Birth *

Year of Birth *

Work Phone # *

Cell Phone

Home Phone *

Employer Name

Additional Parent Information

Name

Month of Birth

Day of Birth

Year of Birth

Work Phone #

Cell Phone

Home Phone

Employer Name

Primary Orthodontic Insurance

Policy Holder's Name

Month of Birth

Day of Birth

Year of Birth

Social Security Number

Employer Name

Insurance Company

Insurance Company Address

City:

Insurance Company Phone #

Group / Plan #

Relationship to Patient

What are the main concerns you would like orthodontics to address?

Tell us your concerns

Has your child ever had or been evaluated for orthodontic treatment before?

Have adenoids or tonsils been removed?

Yes No

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

○ Yes ◉ No

If yes, which ones?

Does your child brush his/her teeth daily?

◉ Yes ○ No

Does your child floss his/her teeth daily?

◉ Yes ○ No

Childs Physician

Phone

Date of last visit

Is your child currently under the care of a physician?

○ Yes ◉ No

Please describe your child's physical health

○ Excellent ○ Good ○ Fair ○ Poor

Please list all medications that your child is currently taking and for what conditions

Please list any medications that your child is currently allergic to.

Has your child ever had any of the following medical issues? (It is required to fill out each one in this section in order to complete and submit this form).

Abnormal Bleeding *

○ Yes ◉ No

Allergies to any drugs *

○ Yes ◉ No

Allergy to latex/metals *

○ Yes ◉ No

Allergy to plastic *

○ Yes ◉ No

Any Hospital Stays *

○ Yes ◉ No

Any Operations *

○ Yes ◉ No

Asthma *

Yes No

Cancer *

Yes No

Congenital Heart Defect *

Yes No

Convulsions/Epilepsy *

Yes No

Diabetes *

Yes No

Handicaps/Disabilities *

Yes No

Hearing Impairment *

Yes No

Heart Murmur *

Yes No

Hemophilia *

Yes No

Hepatitis *

Yes No

HIV + /AIDS *

Yes No

Kidney / Liver Problems *

Yes No

Rheumatic / Scarlet Fever *

Yes No

Tuberculosis (TB) *

Yes No

Does your child have any of the following habits?

Clenching/Grinding Teeth *

Yes No

Nurse Bottle Habits *

Yes No

Lip Sucking/Biting *

Yes No

Speech Problems *

Yes No

Mouth Breather *

Yes No

Thumb / Finger Sucking *

Yes No

Nail Biting *

Yes No

Tungue Thrust *

Yes No

Please list an emergency contact not living with you

Name

Phone

Address

City, State, Zip

Agree To Terms

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status. I also authorize the dental staff to perform the necessary orthodontic services as needed. I further authorize that photos taken during treatment may be used in journal articles or promotional materials and are the property of our office. I understand that where appropriate, credit bureau reports may be obtained.

Yes

I Agree to the above terms and conditions *