Choice Orthodontics
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Orthodontic Patient Information Sheet: About Your Child

Name: ____
Preferred Name: ______________________________________Gender: ____________________
Date Of Birth: ____________________Age:____________Phone:__________________________
Home Address: ____
City: _____________________________________State:___________Zip:___________________
Email: ____
School: ____Grade:__________________
List Siblings Along With Ages: ____
How Did You Hear About Us: ____

Parent Information

	Mother	Father
Name:	______________________________	______________________________
Address (if different):	______________________________	______________________________
Phone (if different):	______________________________	______________________________
Cell Phone:	______________________________	______________________________
Cell Phone Carrier:	______________________________	______________________________
Email:	______________________________	______________________________
Date Of Birth:	______________________________	______________________________
Employer:	______________________________	______________________________
Work Phone:	____________________Ext: ________	____________________Ext:________
Can You Be Called At Work?	______________________________	______________________________

Orthodontic Insurance

	Primary	Secondary
Subscriber Name:	______________________________	______________________________
Subscriber ID (SSN):	______________________________	______________________________
Subscriber Date Of Birth:	______________________________	______________________________
Relationship:	______________________________	______________________________
Employer:	______________________________	______________________________
Insurance Carrier:	______________________________	______________________________
Group Number:	______________________________	______________________________

(Please complete other side)

Medical History

Child's Physician: ____Date of Last Visit: ______________
Is Your Child Currently Under The Care Of A Physician? ____Y ____N
Describe Your Child's Physical Health: ____Good ____Fair ____Poor
List Any Medications Your Child Is Currently Taking: ____
List Any Medications Your Child Is Allergic To: ____
Please List Any Medical Conditions Your Child Has: _______________________________________

Has Your Child Had Any Of The Following Medical Problems?

Y N Allergic to Latex/Metals/Plastic
Y N Any Hospital Stays/Operations
Y N Asthma
Y N Blood Disorder
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Heart Valve Defect
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Previous Infective Endocarditis
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis
Other___________________________

Does Your Child Need An Antibiotic Prior To Dental Work
Due To A Medical Problem? ____Y ____N

Dental History

Do You Have A Specific Orthodontic Concern You Want The Doctor To Address? ______________
Have You Previously Had An Evaluation for Orthodontic Treatment? ____Y ____N
Have There Been Any Injuries To The Face, Mouth, Teeth Or Chin? ____Y ____N
Have Adenoids Or Tonsils Been Removed? ____Y ____N
Has Your Child Been Informed Of Any Missing Or Extracted Teeth? ____Y ____N
Has There Been Any Pain In Your Child's Jaw Joint (TMJ/TMD)? ____Y ____N
Does Your Child Gag When They Brush Their Teeth? ____Y ____N
General Dentist: _________________________________ Date Of Last Visit: ___________________
Do We Have Permission To Send Information To Your Dentist? ____Y ____N

Does Your Child Have Any Of The Following Habits?

Y N Clenching/Grinding Teeth
Y N Lip Sucking
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

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 my child's medical status. I authorize the dental staff to perform necessary dental services my child may need.

Signature of Parent/Guardian: ________________________________ Date: __________________