Child's Form

First Name_________________________ Last Name:_________________________ Date______________

Birthdate____________ Age______ Grade_______ Height_______ Male or Female

Siblings names and ages____

Parent's Or Guardian's Information: Home Phone # ( )___________ *Cell # ( )*_______________

Father:_______________________ Address_______________________ City_________________ Zip_______
Occupation:_____________________ Employer_________________ **Business Phone( )**_____________
Mother:_______________________ Address:_______________________ City_________________ Zip_______
Occupation______________________ Employer_________________ **Business Phone( )**_____________

Marital Status of parents: Married Divorced Separated Widowed

Child Lives with____________ Person responsible for account_________________

Who referred your child to us?____________________

ORTHODONTIC INSURANCE INFORMATION: Do you have Orthodontic insurance? yes no not sure

- **PRIMARY INSURANCE**_________________________________ **Group #**_____________________

Name of subscriber:____

Social Security number:__________________________________ **Date of Birth**___________________

- **SECONDARY INSURANCE**_______________________________ **Group #**_____________________

Name of subscriber: ____
Social security number:__________________________________ **Date of Birth**___________________
Patients Dentist:_____________________________________ **City**_______________ **last visit**__________
List any injury or operation to face, mouth or teeth:________________________________

Please check any that apply:

- ☐ **Thumb or fingers sucking? Until what age?**____________
- ☐ **Grind or clench your teeth during the day or night?**
- ☐ **Difficulty chewing?**
- ☐ **Pain or noise from jaw joint or inability to open wide or move jaw normally ?**
- ☐ **Prior orthodontic work or consultation?**
- ☐ **Concerned about the appearance of your teeth**
- ☐ **Primary reason for seeing an Orthodontist?**_________________________________
- ☐ **Missing or extra teeth? Mother's height**__________ **Father's height**__________

Please circle any that apply:

Y N rheumatic fever
Y N endocrine disorders
Y N high blood pressure
Y N asthma or hay fever
Y N radiation treatment
Y N ear problems
Y N ADHD or ADD
Y N immune deficiency or HIV
Y N emotional problems
Y N lung disease
Y N anemia
Y N sinus problems
Y N behavior problems
Y N slow in learning
Y N speech problems
Y N nervous disorders
Y N cancer/tumors
Y N epilepsy
Y N liver trouble
Y N bone disorder
Y N arthritis
Y N Have Tonsils or Adenoids been removed?

Physician____________________ **City**_______________________ **last visit**__________
Currently under treatment for:____
Medication now being taken:____
List any drug sensitivity or allergies:_______________________________________
PLEASE BRING THIS FORM TO YOUR APPOINTMENT
SIGNATURE______________________________ **SS#**______________________