



PATIENT INFORMATION - CHILD OR TEEN

PATIENT'S NAME _____ DATE OF BIRTH _____
 FIRST MIDDLE LAST

PREFERRED NAME _____ MALE FEMALE PATIENT'S HOME PHONE _____

PATIENT'S ADDRESS _____
 STREET CITY STATE ZIP

PATIENT'S GENERAL DENTIST _____ HOW LONG SINCE THE LAST DENTAL VISIT? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HAVE WE TREATED A FAMILY MEMBER OR FRIEND? YES NO IF YES, NAME(S) _____

NAME OF INDIVIDUAL FILLING OUT THIS FORM _____
 FIRST MIDDLE LAST

RELATIONSHIP TO PATIENT _____ DO YOU HAVE LEGAL CUSTODY YES NO

IS THIS THE CHILD'S FIRST VISIT TO AN ORTHODONTIST? YES NO

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO CORRECT? _____

IS THERE ANYTHING THAT YOU WOULD LIKE TO DISCUSS WITH DR. NEWELL IN PRIVATE? YES NO

PARENTS' INFORMATION

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMAIL: _____ (FOR APPOINTMENT REMINDERS AND OFFICE COMMUNICATION)

FATHER

FATHER STEP-FATHER GUARDIAN NAME _____
 FIRST MIDDLE LAST

ADDRESS (IF DIFFERENT THAN CHILD'S) _____ BIRTHDATE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ SS# _____

EMPLOYER _____ OCCUPATION _____ EMPLOYER'S PHONE _____

IF FATHER HAS INSURANCE COVERAGE FOR THIS CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION

INSURANCE COMPANY'S NAME _____ GROUP OR PLAN # _____

INSURANCE COMPANY'S ADDRESS _____ PHONE # _____

MOTHER

MOTHER STEP-MOTHER GUARDIAN NAME _____
 FIRST MIDDLE LAST

ADDRESS (IF DIFFERENT THAN CHILD'S) _____ BIRTHDATE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ SS# _____

EMPLOYER _____ OCCUPATION _____ EMPLOYER'S PHONE _____

IF MOTHER HAS INSURANCE COVERAGE FOR THIS CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION

INSURANCE COMPANY'S NAME _____ GROUP OR PLAN # _____

INSURANCE COMPANY'S ADDRESS _____ PHONE # _____

DENTAL AND MEDICAL HISTORY

CHILD'S PHYSICIAN _____ DATE OF LAST PHYSICAL _____

IS THE CHILD CURRENTLY UNDERGOING ANY MEDICAL TREATMENT? YES NO

IF YES, FOR WHAT REASON _____

HISTORY OF MAJOR ILLNESS? YES NO IF YES, PLEASE DESCRIBE _____

HISTORY OF TRAUMA OR INJURY TO THE FACE OR TEETH? YES NO IF YES, PLEASE DESCRIBE _____

ANY SENSITIVITIES OR ALLERGIES (LATEX, ANTIBIOTICS, ETC.)? YES NO IF YES, PLEASE LIST _____

CURRENTLY TAKING ANY MEDICATIONS? YES NO IF YES, PLEASE LIST _____

HAS THE CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

- | | | | | |
|------------------------------------|---|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CANCER | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> NERVOUS DISORDER | <input type="checkbox"/> ADD/ADHD |

DOES THE CHILD REQUIRE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? YES NO

HAVE THE ADENOIDS OR TONSILS BEEN REMOVED? YES NO

HAS THE CHILD EVER HAD PAIN OR TENDERNESS IN THE JAW JOINT (TMJ)? YES NO

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

- | | | |
|--|---|--|
| <input type="checkbox"/> TEETH GRINDING | <input type="checkbox"/> FINGER/THUMB SUCKING | <input type="checkbox"/> PROLONGED BOTTLE/PACIFIER |
| <input type="checkbox"/> MOUTH BREATHING | <input type="checkbox"/> SPEECH PROBLEMS | <input type="checkbox"/> CHEWING/EATING PROBLEMS |

SIGNATURE

I UNDERSTAND THAT THE INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS.

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATED TO PROCESSING OF INSURANCE. I CONSENT TO EXAMINATION BY THE DOCTOR AND AUTHORIZE PAYMENT OF ANY INSURANCE BENEFITS DIRECTLY TO THIS OFFICE.

SIGNATURE _____ DATE _____