Child Patient Information

BRACES4ALL® ORTHODONTICS

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Patient's Name:_____ Prefers to be called:_____ Sex:_____
Address:_____ City:_____ Prov:_____ Postal Code:_____
Patient resides with: [ ]Both parents [ ]Mother [ ]Father [ ]Other _____
Cell Phone:_____ Home Phone:_____
Age:_____ Birthdate:_____
Please describe your child's orthodontic concern(s) in your own words:_____
Who may we thank for referring you to our office? _____

	Parent 1	Parent 2
Salutation	[ ] Ms. [ ] Mrs. [ ] Mr. [ ] Dr.	[ ] Ms. [ ] Mrs. [ ] Mr. [ ] Dr.
Name	_____	_____
Address	_____	_____
Cell Phone	_____	_____
E-mail	_____	_____
Employer	_____	_____
Business Address	_____	_____
Business Number	_____	_____
Occupation	_____	_____

Parent 1 & 2's Marital Status:
[ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single [ ] Common-law

Parent 1's Relationship to Patient:
[ ] Biological Parent [ ] Step Parent [ ] Grandparent [ ] Other_____

Parent 2's Relationship to Patient:
[ ] Biological Parent [ ] Step Parent [ ] Grandparent [ ] Other_____

Step Parents name(s):_____
Person(s) Responsible for Account:_____

Please note: We can assist you with your dental claim form. If you have **orthodontic benefits** please complete below.

1. Ins. Co. Name:_____ 2. Ins. Co. Name:_____
Policy Number:_____ Policy Number:_____
Identification #:_____ Identification #:_____
Policy Holder's Name:_____ Policy Holder's Name:_____
Policy Holder's DOB:_____ Policy Holder's DOB:_____
Employer:_____ Employer:_____

OVER

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All the information will be kept confidential.

Physician's name:_____Address:_____Phone:_____

Has your child experienced any health problems?	[ ] No [ ] Yes	Explain: _____
Any major change in your child's health recently?	[ ] No [ ] Yes	Explain: _____
Is your child currently under a physician's care?	[ ] No [ ] Yes	Explain: _____
In your child currently taking any medications?	[ ] No [ ] Yes	Explain: _____
Is your child allergic to any medications?	[ ] No [ ] Yes	Explain: _____
Has your child ever received a blood transfusion?	[ ] No [ ] Yes	Explain: _____
Has your child 's tonsils and/or adenoids been removed?	[ ] No [ ] Yes	Explain: _____
Has your child been in a risk group for AIDS?	[ ] No [ ] Yes	Explain: _____

Please check if your child has had any of the following conditions:

Heart Murmur	[ ] No	[ ] Yes	Hepatitis	[ ] No	[ ] Yes	Emotional Problems	[ ] No	[ ] Yes
Heart Surgery	[ ] No	[ ] Yes	Diabetes	[ ] No	[ ] Yes	Nervous/Anxious	[ ] No	[ ] Yes
Rheumatic Fever	[ ] No	[ ] Yes	Kidney Disease	[ ] No	[ ] Yes	Cancer	[ ] No	[ ] Yes
Endocrine Disorders	[ ] No	[ ] Yes	Tuberculosis	[ ] No	[ ] Yes	Bone Disorders	[ ] No	[ ] Yes
Prolonged Bleeding	[ ] No	[ ] Yes	Bronchitis	[ ] No	[ ] Yes	Growth Disorders	[ ] No	[ ] Yes
Anemia,Blood Disorders	[ ] No	[ ] Yes	Asthma	[ ] No	[ ] Yes	Herpes (Fever Blisters)	[ ] No	[ ] Yes
Development Disorder	[ ] No	[ ] Yes	Epilepsy	[ ] No	[ ] Yes	Tonsillitis	[ ] No	[ ] Yes
Hives /Rash	[ ] No	[ ] Yes	Fainting	[ ] No	[ ] Yes	Respiratory Allergies	[ ] No	[ ] Yes

Is there any other condition, allergy or problem that you think we should know about?_____

_____

Comments:_____

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty? [ ]No [ ]Yes Explain_____

Girls - Has she started menstruation? [ ]No [ ]Yes Explain_____

Child's Height _____ Do you feel growth is completed? [ ]No [ ]Yes

Father's Height_____ Mother's Height_____ Adopted [ ]No [ ]Yes

Name(s) and birthdate(s) of patient's siblings_____

Have either siblings or parents had orthodontic treatment? [ ]No [ ]Yes

Dentist's Name:_____ Address:_____Phone:_____

Frequency of Dental checkups: [ ] Twice a Year [ ] Once a year [ ] Only if a problem exists Date of last visit: _____

Is there any unfinished care to be completed with your child's dentist?	[ ] No [ ] Yes	Explain: _____
Is your child frightened about dental treatment?	[ ] No [ ] Yes	Explain: _____
Has your child had an unpleasant experience in a dental office?	[ ] No [ ] Yes	Explain: _____
Has your child had any facial or dental injuries?	[ ] No [ ] Yes	Explain: _____
Is there a history of thumb or finger sucking?	[ ] No [ ] Yes	Explain: _____
Does your child play any mouth musical instruments?	[ ] No [ ] Yes	Explain: _____
Have teeth (either primary or permanent) been removed?	[ ] No [ ] Yes	Explain: _____
Have you consulted an orthodontist regarding your child previously?	[ ] No [ ] Yes	With Whom:_____
Has your child had any previous orthodontic treatment?	[ ] No [ ] Yes	With Whom:_____
Are you satisfied with your child's previous orthodontic treatment?	[ ] No [ ] Yes	Explain: _____
Have you noticed any change in your child's bite or dental alignment recently?	[ ] No [ ] Yes	Explain: _____

Please check if your child has or has had a history of:

[ ] Clenching teeth [ ] Muscular soreness around head & neck [ ] Jaw joint soreness [ ] Jaw joint popping

[ ] Grinding teeth [ ] Headaches (more than normal) [ ] Jaw joint clicking [ ] Ringing in the ears

[ ] Speech problems (if so which sounds?)_____ Mouth breathing: Awake_____ Asleep_____

Is there other information that may be helpful?_____

Parent/Guardian Signature_____Date_____ Office review by:_____