



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 TELL US ABOUT YOUR CHILD

Today's Date:
Child's Name: Last First M. Ini.
Child's Birthdate: Age
Nickname: Female Male
School: Grade:
Hobbies/Sports:
Child's Home#: SSN
Child's Home Address: City State Zip
Whom may we thank for referring you?
General/Pediatric Dentist:
Last Exam Date: Any cavities? Y N

2 WHO IS ACCOMPANYING THE CHILD TODAY?

Name: Relation:
Do you have legal custody of this child? Y N
Child resides with: Mother Father Other
Is there a Court Order regarding child's residence? Y N
Parent's Marital Status: Single Married Widowed Divorced Separated

3 PARENT'S INFORMATION

Father Step Father Guardian
Name: TDL#:
Wk#: Ext.
Hm#:
Cell#:
Email:
Address (if different from above)
Employer:
Mother Step Mother Guardian
Name: TDL#:
Wk#: Ext.
Hm#:
Cell#:
Email:
Address (if different from above)
Employer:

4 PERSON RESPONSIBLE FOR ACCOUNT

Name: Relation:
Billing Address: City State Zip
Hm#: TDL#:
Employer:
Wk#: Ext.
Cell#:
SSN:

5 PRIMARY DENTAL INSURANCE

Dental Coverage? Yes No Ortho? Yes No
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone#:
Group# (Plan, Local, or Policy #):
Policy Owner's Name:
Relationship to Patient:
Policy Owner's DOB:
Policy Owner's SSN:

Please inform us if you have secondary dental insurance

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

Y N Clenching/Grinding Y N Food impaction
Y N Lip Sucking/Biting Y N Pain around ear
Y N Mouth Breather Y N Bad Breath
Y N Nail/Cheek Biting Y N Water Jet Device
Y N Fluoride supplements Y N Burning Tongue
Y N Teeth sensitive to cold,heat, sweets or pressure
Y N Swelling or lumps in mouth
Y N Periodontal Treatment
Y N Cigarette/Tobacco use
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Any dental problem not listed above
If Yes, please describe:

7

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#:() _____

Date of Last Visit: _____

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:
 Good Fair Poor

Please list all drugs that the child is currently taking:

Please list all drugs/things that the child is allergic to:

Please notify us if your child gets pregnant to avoid the taking of dental x-rays during treatment.

8

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

- | | |
|--|--------------------------|
| Y N Abnormal Bleeding | Y N Thyroid Issues |
| Y N Allergies to Any Drugs | Y N Malignancies |
| Y N Allergic to Latex/Metals | Y N Epilepsy/Seizures |
| Y N Allergic to Plastics | Y N Radiation Treatment |
| Y N Any Hospital Stays | Y N Joint Replacement |
| Y N Any Operations | Y N Learning Disability |
| Y N Arthritis | Y N Difficulty Breathing |
| Y N Artificial Valves | Y N Eye Disorders |
| Y N Asthma | Y N Ulcers/Colitis |
| Y N Hay Fever/Allergies | Y N Venereal Disease |
| Y N Cancer/Chemotherapy | Y N Drug Abuse |
| Y N Congenital Heart Defect | Y N Emphysema |
| Y N Glaucoma | Y N Sinus Problems |
| Y N Diabetes | Y N Fever Blisters |
| Y N Handicaps/Disabilities | Y N Hepatitis |
| Y N Hearing Impairment | Y N Pacemaker |
| Y N Heart Murmur | Y N Headaches |
| Y N Mitral Valve Prolapse | Y N Migraines |
| Y N Heart Ailments | Y N Shingles |
| Y N Anemia/Hemophilia | Y N Heart Attack |
| Y N High/Low Blood Pressure | Y N HIV +/- AIDS |
| Y N Kidney/Liver Problems | Y N Psychiatric Care |
| Y N Rheumatic/Scarlet Fever | |
| Y N Tuberculosis (TB) | |
| Y N Any medical issue not listed above | |

If Yes to any above, please describe:

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 the necessary dental services my child may need even if I am not present in the treatment area.

Signature of parent or guardian _____ Date _____

I authorize and direct payment of the dental benefits offered by my dental insurance for treatment performed to Fullerton Orthodontics. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with treatment performed.

Signature of parent or guardian _____ Date _____

DOCTOR USE ONLY BELOW

I verbally reviewed the medical/dental information above with the parent/guardian named herein.
Doctor Comments: _____ Initials: _____ Date: _____

