

CHILD INFORMATION

TODAY'S DATE _____

PATIENT INFORMATION

Last Name: _____ First Name: _____
 Nickname: _____ Birthdate: _____
 Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 School: _____ Grade: _____
 Siblings and Age: _____

PARENTS/GUARDIANS INFORMATION

Parent/Guardian 1 (circle one)

Last Name: _____ First Name: _____

Social Security#: _____ Birthdate: ____/____/____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Relationship to Patient: Biological Step Adopted Foster Other: _____

Parent/Guardian 2 (circle one)

Last Name: _____ First Name: _____

Social Security#: _____ Birthdate: ____/____/____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Relationship to Patient: Biological Step Adopted Foster Other: _____

Parents Marital Status: Married Divorced Separated Single Widow/Widower

Patient Lives With (check all that apply): Mother Father Grandparent Stepmother Stepfather Other:

FINANCIAL RESPONSIBILITY

Individual Responsible For This Account: _____ Relationship To Patient: _____

Address: _____ City: _____ Zip Code: _____

Best Number To Be Reached At: _____ Birthdate: ____/____/____

DENTAL INSURANCE

Is the patient covered by dental insurance or medical assistance? Yes No

Primary Insurance Company: _____

Primary Insured: Last Name: _____ First Name: _____ SSN: _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Initials: _____

Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: Excellent Good Fair Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

Please list any **allergies**: _____

Is your child currently taking any medications (pills, drugs, injections, etc.)? Please list them here: _____

Has the patient ever taken intravenous bisphosphonates such as: Zometa, Aredia or Didronel? Yes No

Has the patient ever taken oral bisphosphonates such as: Fosamax, Actonel, Boniva, Skelid or Didronel? Yes No

Has the patient ever taken other bone antiresorptive medication? Yes No If yes, check all that apply:

Denosumab (Prolia®) Calcitonin (Miacalcin®, Fortical®) Teriparatide (Forteo) Raloxifene (Evista®)

If female, has menstruation begun? Yes No If yes, when? _____

If female, is the patient pregnant or is there any possibility they might be pregnant? Yes No

Does the patient presently have or have they **ever had** any of the following?

- | | | |
|--|---|---|
| Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Seizures/Fainting spells .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial bone/joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adenoids/Tonsils Removed..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Learning Disability..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS or HIV+..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia/ Abnormal Bleeding... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus/Breathing Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High/Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy/Radiation.. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Syphilis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis/TB..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other _____ | | |

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? Yes No

Initials: _____

Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: Excellent Good Fair Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

Please list any **allergies**: _____

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| Other _____ | | |

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? Yes No

Initials: _____

Does the patient have any of the following problems regularly (once a week or more) during sleep?

PROBLEM		If Yes, Age of Onset	Days per Week
Snoring or Noisy Breathing.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Choking and Gasping in Sleep.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Stopping Breathing.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Struggling to Breathe.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mouth Breathing/ Trouble Breathing Through Nose.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Difficulty Swallowing/ Drooling.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Restless Sleep / Tossing and Turning.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Frequent Leg Movements.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Teeth Grinding.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sleep Walking.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Body Rocking/ Head Banging.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Awakening Frightened / Screaming.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bed Wetting.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Night Sweating.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

AUTHORIZATIONS

I authorize the release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

I certify that the above information is accurate and understand that an appropriate credit bureau report may be obtained.

I have read the above questions and understand them. I will not hold my child's orthodontist or any member of her team responsible for any errors or omissions that I have made in the completion of this form.

I will notify my child's orthodontist of any changes in their medical or dental history.

Signature: _____ Date: _____