CHILD

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ORTHODONTIST

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Patient Information

Child's Legal Name: ____________________ Preferred Name: ____________ Male [ ] Female [ ]
Birthdate: __________ Age: ________ Email: ____________________
Home Address: ____________________
City: ______________ State: ______________ Zip: __________
School: ______________ Grade: ________ Hobbies/Sports: ______________
____

Siblings (names & ages): ____________________
Family Dentist: ______________ Last Visit: ______ Physician: ______________
Whom may we thank for telling you about us? (dentist, friends, family members) ______________
____

Has any member of your family been a patient in our office? Yes [ ] No [ ]
Names: ____________________
Who will be accompanying your child? ______________ Relationship: __________
With whom does the patient live? ____________________
Parents' Marital Status: Married [ ] Divorced [ ] Widowed [ ] Single [ ] Separated [ ]

	Father / Stepmother	*Mother / Stepfather*
Names		
Address		
City, State, Zip		
SS #	DOB:	DOB:
Drivers License		
Employer		
Home Phone		
Work Phone		
Cell Phone		
Permission to contact at work?		

Is patient covered by orthodontic insurance? Yes [ ] No [ ] If yes, please bring card with you.
Name of insurance ____________________
Neighbor or relative not living with you: ____________________
Address & Phone # (In case of emergency): ____________________
What are the main concerns that you and your child would like orthodontics to accomplish? __________
____
____

Has your child:

ever been evaluated or had orthodontic treatment before Yes [ ] No [ ]

If yes, by whom? ________________________________

ever had any injuries to the face, mouth, teeth, chin Yes [ ] No [ ]

had adenoids or tonsils removed Yes [ ] No [ ]

ever been informed of any missing/extra teeth Yes [ ] No [ ]

ever had any pain/tenderness/clicking in the jaw joint Yes [ ] No [ ]

Does/did your child have any of the following habits:

clenching/grinding teeth (at night) Yes [ ] No [ ]

mouth breather Yes [ ] No [ ]

nail biting Yes [ ] No [ ]

speech problems Yes [ ] No [ ]

tongue thrust Yes [ ] No [ ]

thumb, finger, lip sucking or biting Yes [ ] No [ ]

Does your child brush his/her teeth daily? Yes [ ] No [ ]

Are all vaccinations current? Yes [ ] No [ ]

Is your child in good health? Yes [ ] No [ ]

Has your child had any history of:
(If applicable, please circle)

allergies to latex, plastic or any metals Yes [ ] No [ ]

asthma, tuberculosis (TB), allergies or hay fever Yes [ ] No [ ]

congenital heart defect or heart murmur Yes [ ] No [ ]

convulsions, epilepsy, or siezures Yes [ ] No [ ]

diabetes, kidney or liver problems Yes [ ] No [ ]

hemophilia, hepatitis, HIV+/AIDS Yes [ ] No [ ]

hospital stays or operations Yes [ ] No [ ]

hearing impairment, handicaps, or disabilities Yes [ ] No [ ]

rheumatic or scarlet fever Yes [ ] No [ ]

Has puberty/menstruation begun? Yes [ ] No [ ]

Does your child chew, smoke or use e-cigarettes? Yes [ ] No [ ]

Please discuss any medical problems that your child has/had:________________________________

____

Please list all medications your child is currently taking: ________________________________

____

Please list all medications your child is allergic to: ________________________________

____

I understand 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 that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the staff to perform the necessary dental services my child may need. I acknowledge that I have received a copy of the Notice of Privacy Practices of the office of Joseph R. Gregg DDS, MSD. I authorize the release of rights to photographs and orthodontic records for the use by Joseph R. Gregg DDS, MSD.

Signature of parent or guardian: ________________________________ *Date:* ____________________

update:

For Office Use Only

Name	*Initial*	*Date*

I verbally reviewed the health information above with the parent/guardian and patient named herein.

Name: ________________________________ **Date:** ____________________