

# Child Patient Information

Patient's Name: \_\_\_\_\_  
Last First

I prefer to be called: \_\_\_\_\_

**Male** or **Female** Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_

Brothers/Sisters and ages: \_\_\_\_\_  
\_\_\_\_\_

General Dentist: \_\_\_\_\_

Personal Physician: \_\_\_\_\_

Lives with: **Mother** **Father** **Both** **Other:** \_\_\_\_\_

Name: \_\_\_\_\_

**Single** **Married** **Partnered** **Separated** **Divorced** **Widowed**

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

How long there: \_\_\_\_\_  
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Person Responsible for Account: **Mother** **Father** **Other**

Is this the person who is listed as the Insured on the child's  
orthodontic insurance policy? **Yes** **No**

If **Non-Custodial Parent** or **Other**, please provide:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
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Whom may we thank for referring you? \_\_\_\_\_

What are the main concerns that you would like orthodontics  
to accomplish? \_\_\_\_\_

Today's Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Custodial Parent Cell Phone:  
\_\_\_\_\_

Child Cell Phone: \_\_\_\_\_  
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In the event of an emergency,  
nearest adult friend or relative not  
living with the child:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_  
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## Orthodontic Insurance

Do you have an insurance card we  
may copy? **Yes** **No**

If **No**, please provide Ins. Company ...

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Group No: \_\_\_\_\_

Policy No: \_\_\_\_\_

ID No: \_\_\_\_\_

## Child Patient Information

Any drugs that your child is currently taking: \_\_\_\_\_  
 \_\_\_\_\_

Allergies: \_\_\_\_\_

Child's current medical health:   **Good**           **Fair**           **Poor**

Has puberty begun? \_\_\_\_\_

Has menstruation begun? \_\_\_\_\_

Has child been evaluated or had orthodontic treatment before?  
 \_\_\_\_\_

Any injuries to the face, mouth, teeth or chin? \_\_\_\_\_

Does child play musical instrument involving mouth? \_\_\_\_\_

Adenoids or tonsils removed? \_\_\_\_\_ Date: \_\_\_\_\_

Has the child complained of pain/tenderness in the jaw joint? \_\_\_\_\_

Does child brush teeth daily? \_\_\_\_\_ Floss daily? \_\_\_\_\_

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**Habits**

Clenching/grinding teeth?   **Y N**           Speech problems?   **Y N**

Thumb/finger sucking?       **Y N**           Tongue thrust?       **Y N**

Nail biting?                   **Y N**           Lip sucking/biting?   **Y N**

Mouth breather?              **Y N**

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 I understand that the information 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 Dr. Baker and staff to take the necessary x-rays and records and perform the orthodontic services my child may need.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

\_\_\_\_\_  
 Parent or Guardian

\_\_\_\_\_  
 Date

Has your child had any of the following medical conditions?  
**(Please circle any that apply)**

- Abnormal bleeding
- ADD/ADHD
- Allergic to latex or metals
- Allergic to plastic
- Hospital stays
- Operations
- Artificial bones/joints/valves
- Asthma
- Cancer
- Congenital Heart Defect
- Convulsions/Epilepsy
- Diabetes
- Handicaps/Disabilities
- Hearing Impairment
- Heart Murmur
- Hemophilia
- Hepatitis
- HIV/AIDS
- Kidney/Liver problems
- Lupus
- Rheumatic/Scarlet Fever
- Tuberculosis
- Other: \_\_\_\_\_