Child Patient Information

We would like to welcome you and your child to our office.
Our goal is to make everyone's visit pleasant and educational.
Please fill out the information below:

Today's Date _____

Child's name _____ Nickname _____
LAST FIRST MI

☐Male ☐Female Birth date _____ Age ____ Home # _____ Cell # _____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

School _____ Grade _____

Hobbies/Sports _____

Who is accompanying your child today? _____ Do you have legal custody of this child? ☐Yes ☐No

Whom may we thank for referring you? _____

Please list your child's siblings' names and ages _____

General dentist _____ Date of Last Visit _____

Parent's marital status ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Mother's Information ☐Mother ☐Stepmother ☐Guardian ☐Other _____

Name_____ SS#_____ Home #_____ Cell #_____ Birth date_____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

E-mail _____ Employer _____ Work # _____

Job title _____

Father's Information ☐Father ☐Stepfather ☐Guardian ☐Other _____

Name_____ SS#_____ Home #_____ Cell #_____ Birth date_____

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

E-mail _____ Employer _____ Work # _____

Job title _____

Person Responsible for Account _____ SS# _____

Home # _____ Cell # _____ Relationship _____

Home Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

Previous Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

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1403 Tucker Road • North Dartmouth, Massachusetts 02747 • p: (508) 990-1499 • f: (877) 496-6187

Primary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

Secondary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

Child's Health History

What are the main concerns that you would like the orthodontist to address? _____

_____

Has your child ever been evaluated for or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Have adenoids and/or tonsils been removed? ☐ Yes ☐ No

Has your child ever had any of the following diseases/medical problems?

☐ Yes ☐ No Abnormal bleeding	☐ Yes ☐ No Convulsions/epilepsy	☐ Yes ☐ No Lip sucking/biting
☐ Yes ☐ No Allergic to latex/metals	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Nail biting
☐ Yes ☐ No Allergies to any drugs	☐ Yes ☐ No Hearing impairment	☐ Yes ☐ No Rheumatic/scarlet fever
☐ Yes ☐ No Asthma	☐ Yes ☐ No Heart murmur	☐ Yes ☐ No Speech problems
☐ Yes ☐ No Cancer	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Thumb/finger sucking
☐ Yes ☐ No Clenching/grinding teeth	☐ Yes ☐ No HIV/AIDS	☐ Yes ☐ No Tongue thrust
☐ Yes ☐ No Congenital heart defect	☐ Yes ☐ No Kidney/liver problems	☐ Yes ☐ No Tuberculosis (TB)

Please discuss any medical conditions that your child may have _____

Child's physician _____ Phone # _____

Date of last visit _____ Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health ☐ Good ☐ Fair ☐ Poor

Please list any prescriptions/over the counter drugs your child is taking _____

Please list any drugs/materials/foods/flavorings (mint, cinnamon, etc.) that your child is allergic to _____

_____

I understand 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.

Signature _____ Date _____

Doctor's Comments _____

_____