Child Patient Information

(under 18 years of age)

Name _____ Nickname _____ Date of Birth _____ Age _____ Gender _____

Address _____

Parent(s) Name(s) _____ Parents' Marital Status _____

Patient lives with _____

Phone: Home _____ Mobile _____ Other _____

E-mail Address (Mother) _____ (Father) _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Employer _____ Occupation _____ Work Phone _____

School _____ Grade _____ Sports/Interests _____

Siblings: Ages _____ Have any family members been seen at our office? (Names) _____

Whom may we thank for referring you to our office? ❑ General Dentist ❑ Friend ❑ Other _____

Responsible Party Information

Responsible Party _____ Relationship to patient _____

Mailing Address _____

Phone: Home _____ Mobile _____ Other _____

Social Security # _____ E-mail Address _____

Dental Insurance Information

Insured's Name. _____ Insured's Social Security# _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes _____ No _____ If yes: _____

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone _____

Emergency Information

Name of emergency contact (other than parent) _____

Relationship to patient _____ Phone(s) _____

Person(s) OK to release appointment or medically related information to concerning child. _____

Relationship to child _____

Please complete BOTH sides of form

Updates (Date & Initial) _____ _____ _____

Child's Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is patient taking any medication? _____

Yes No Is patient allergic to any medication? _____

Yes No Does patient have a history of a major illness? _____

Yes No Has patient had any major operations? _____

Yes No Has patient ever been involved in a serious accident? _____

Yes No Onset of puberty; (Boys - voice changed); (Girls - started menstruation) _____

Female Patients only: Is the child pregnant? Yes No

Please circle any of the medical conditions below the patient has had or currently has:

ADD/ADHD	Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding	Arthritis
Epilepsy	High Blood Pressure	Radiation/Chemotherapy	Asthma or Hay fever	HIV/Aids
Tuberculosis	Gastrointestinal Disorders	Rheumatic Fever	Bone Disorders	Heart Problems
Kidney problems	Congenital Heart Defect	Tumor or Cancer	Nervous Disorders	Heart Murmur

Is this child in excellent health? (Please circle) Yes / No

Any medical conditions that are not listed above: _____

Child's Dental History

Dentist _____ Date of last visit _____

In your own words what is the problem? _____

Yes No Are they presently in any dental pain? _____

Yes No Have they ever experienced any unfavorable reaction to dentistry? _____

Yes No Have they ever lost or chipped any teeth? _____

Yes No Have there been any injuries to their face, mouth or teeth? _____

Yes No Is any part of their mouth sensitive to temperature or pressure? _____

Yes No Do their gums bleed when they brush? _____

Yes No Do they have any type of thumb or tongue habit? _____

Yes No Are they a mouth breather? _____

Yes No Do their teeth or jaws ever feel uncomfortable when they wake in the morning? _____

Yes No Are you aware of their jaw clicking or popping? _____

Yes No Are you aware of clenching their teeth? _____

Yes No Have you ever been told that they grind their teeth? _____

Yes No Do you think that they might have sleep apnea? _____

Yes No Do they snore? _____

Yes No Do they have "tension" headaches? _____

Yes No Have they ever seen an orthodontist? If yes, who and when? _____

Yes No Would they object to wearing orthodontic appliances (braces) should they be indicated? _____

Yes No Has anyone in their family received orthodontic treatment? Who? _____

How did they feel about the result? Positive / Negative / Other _____

What is the patient's attitude toward receiving orthodontic treatment? Excited / Nervous / Dreading it / Indifferent

Yes No Are you aware that some appointments will be during school / work hours?

Benefits and Limitations

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and may have an atypical response to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I understand that the diagnostic records may be used for educational and training purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in patient's medical or dental history. In addition, I authorize Porter Orthodontics to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

Updates (Date & Initial) _____ _____ _____