Patient Information - Child

Name: _____
Last First MI

Likes to be called: _____

Male: _____ Female: _____ Birthdate: ___/___/___ Age: _____

Current School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: __(_____)_____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

□ Mother □ Step Mother □ Guardian

Name: _____
Last First MI

Birthdate: ___/___/___ Home #: __(_____)_____

Email: _____

Employer: _____

Work #: __(_____)_____ ext: _____

Position/ Title: _____

How long at current job? _____

Do you have dental insurance with ortho coverage? _____

□ Father □ Step Father □ Guardian

Name: _____
Last First MI

Birthdate: ___/___/___ Home #: __(_____)_____

Email: _____

Employer: _____

Work #: __(_____)_____ ext: _____

Position/ Title: _____

How long at current job? _____

Do you have dental insurance with ortho coverage? _____

Who will be responsible for making appointments?

_____

Who will be responsbile for the account?

_____

Email address for appointment reminders:

_____

Would you also like appointment reminders via text messages? □ Yes □ No

If so, phone #: __(____)_____

Optional: Child's cell phone # (for orthodontic reminders): __(____)_____

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

Whom may we thank for referring you to our office?

_____

Other family member seen by us: _____

_____

Number of brothers: ____ Ages: _____

Number of sisters: ____ Ages: _____

Parent's marital status: _____

Patient lives with: _____

Has your child ever been evaluated for (or had) orthodontic treatment? □ Yes □ No

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

If yes: _____

Has your child ever been informed of any missing or extra permanent teeth? □ Yes □ No

Has your child ever had any baby or permanent teeth removed? □ Yes □ No

Has your child had his/her tonsils and/or adenoids removed? □ Yes □ No

Does your child brush his/her teeth at least twice per day? □ Yes □ No

Has patient reached puberty? □ Yes □ No

For girls - has menstruation begun? □ Yes □ No

if so, when: month_____ year _____

Is your child currently experiencing any tooth pain or discomfort? □ Yes □ No

Does your child now have or ever experienced pain, discomfort, popping, or clicking in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Does your child have dental insurance coverage?
□ Yes □ No If yes,

Policy holders name: _____

Date of birth: ___/___/___

Employer: _____

ID# or SS#: _____ GRP#: _____

Name of insurance company:_____

Insurance company phone: _____

Policy holder's adderss: _____

HORTON ORTHO

Phone: (651) 738-9060 8375 City Centre Drive
Fax: (651) 738-7928 Woodbury, MN 55125
www.hortonortho.com

Child's Physician: _____

Physican's #: __(____)_____

Is your child currently under the care of a physican? _____

If so, for what condition? _____

Please list all medications your child is currently taking: _____

_____

Please list all of your child's allergies (including drugs, foods, bee stings, etc.) _____

_____

_____

General or Pediatric Dentist: _____

Date of last cleaning / exam: _____

Has your child ever had any of the following habits?

Clenching	□ Yes	□ No
Grinding	□ Yes	□ No
Nail biting	□ Yes	□ No
Mouth breather	□ Yes	□ No
Lip-sucking/Biting	□ Yes	□ No
Tongue thrusting	□ Yes	□ No
Thumb/finger sucking	□ Yes	□ No
Soda pop drinker	□ Yes	□ No

Has your child ever had any of the following?

Abnormal bleeding/blood disorder	□ Yes	□ No	Hepatitis	□ Yes	□ No
Allergies to any drugs	□ Yes	□ No	High blood pressure	□ Yes	□ No
Allergic to latex	□ Yes	□ No	HIV +/AIDS	□ Yes	□ No
Allergic to metals	□ Yes	□ No	Hospitalization	□ Yes	□ No
Anemia	□ Yes	□ No	Kidney or liver problems	□ Yes	□ No
Arthritis/joint problems	□ Yes	□ No	Mental health concerns	□ Yes	□ No
Asthma	□ Yes	□ No	Migraines	□ Yes	□ No
Bone disorders	□ Yes	□ No	Nerve or brain disease	□ Yes	□ No
Cancer	□ Yes	□ No	Operations	□ Yes	□ No
Congenital heart defects	□ Yes	□ No	Psoriasis	□ Yes	□ No
Diabetes	□ Yes	□ No	Rheumatic/scarlet fever	□ Yes	□ No
Epilepsy/Seizures/convulsions	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Handicaps/disabilities	□ Yes	□ No	Sinus infections	□ Yes	□ No
Hearing impairment	□ Yes	□ No	Sleep apnea	□ Yes	□ No
Heart attack/stroke	□ Yes	□ No	Swollen glands	□ Yes	□ No
Heart murmur	□ Yes	□ No	Ulcers	□ Yes	□ No
Hemophilia	□ Yes	□ No	Tuberculosis	□ Yes	□ No

Comments: _____

_____

Please list any other significant information about the patient's medical history: _____

_____

_____

Has your child ever needed to be premedicated for dental visits? _____

If so, please explain: _____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

_____

Signature of parent or guardian Date

Smile on.