PATIENT INFORMATION FOR PATIENTS UNDER 21 YEARS OF AGE

(Please write in information and bring to your appointment)

Date_____ ACCOUNT # _____

Patient's name_____
Last First Middle Nickname

Street Address _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone (___) _____ Patient's cell phone (___) _____ Patient's Social Security _____

Patient's Birth date_____ Patient's Age_____ Patient's email address_____

School Name_____ Grade_____ Parent or guardian name _____

Patient's dentist_____Whom may we thank for referring you to our office?_____

FAMILY INFORMATION

Father's Information: Name _____
Last First Middle

Street Address _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Cell/other phone _____ Work phone _____

Email address_____ Social Security #_____Employer _____ Occupation _____

Mother's information Name: _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Cell/other phone _____ Work phone _____

Email address _____ Social Security # _____Employer_____ Occupation _____

Parent's Marital Status □ Married □ Single □ Divorced □ Widowed □ Separated (Check one)

Who has legal custody of child? □ Parents □ Father □ Mother □ Other_____

Names and ages of other children in the family_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Insured's Name_____ Insured's Social Security # _____

Insurance Company _____ Insured's birth date _____Insured's Employer_____

Insurance Co. Address _____
Street City Zip

Insurance Group No._____ Insurance Co. Phone No._____

Insured's relationship to patient _____Do you have dual coverage? Yes____ No_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Relationship of nearest relative_____ Home Phone (___) _____ Cell Phone (___) ____

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 the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Has patient seen a physician in the last 12 months? Why? _____
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

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

Please list all allergies & allergic reactions _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____

CHILD'S DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of patient's mouth sensitive to temperature? Where? _____
Yes No Is any part of patient's mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that appointments will be during school hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. 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 can fail to respond 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 have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Engel to perform a complete orthodontic evaluation.

Parent/Legal Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

Recall
1Yr _____
6 Mo _____
3 Mo _____

Teeth to be Extracted
_____
_____

Case Fee _____