

CHILD PATIENT INFORMATION

Tell us about your child

Child's Name: _____ DOB: _____
Age: _____

Preferred Name: _____ Male Female

School: _____ Grade: _____

Home #: _____ Cell#: _____

Email: _____

Hobbies/ Special Interests: _____

Child's Home Address: _____

CITY _____ State _____ ZIP _____

Who is with your child today?

Name: _____

Relationship: _____

Do you have legal custody of this child: Yes No

Whom may we thank for referring you? _____

General Dentist: _____

General Dentist #: _____

Date of last visit: _____

Parent's Marital Status Single Widowed Married Divorced

Mother's Information

Name: _____

Work #: _____ Home # _____

Employer: _____

SS#: _____

Father's Information

Name: _____

Work #: _____ Home# _____

Employer: _____

SS#: _____

Account Holder Information

Name: _____

Billing Address: _____

City _____ State _____ Zip _____

Work #: _____ Home # _____

Cell #: _____

Email: _____

Employer: _____

Primary Dental Insurance

Ins Name: _____

Ins Address: _____

Ins Co #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____

Secondary Dental Insurance

Ins Name: _____

Ins Address: _____

Ins Co #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____

CHILD PATIENT INFORMATION

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

Has your child ever been evaluated or had orthodontic treatment before

Yes No- if yes, Who? _____

Have there been any injuries to the face, mouth, teeth or chin?

Yes No

Have adenoids or tonsils been removed? Yes No

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

Has your child ever had any pain/tenderness in the jaw?

Yes No

Does your child brush his/her teeth twice daily?

Yes No

Floss his/her teeth daily? Yes No

Please list any musical instruments your child plays:

Does the child exhibit any of the following behaviors?

YES NO

- Nail Biting
 Thumb Sucking
 Teeth Grinding (Bruxism)
 Open Mouth Breathing
 Speech Impairment
 Tongue Thrust (reverse swallow)

Medical History Updates:

Initial: _____ Date: _____

Initial: _____ Date: _____

Our office is committed to meeting and exceeding standards of infection control as mandated by OSHA, the CDC, and the ADA.

Health History

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Def.
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine/Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Stays
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Any Drug
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea

Please discuss any serious medical problems that the child has had:

Does your child normally medicate before each dental visit? Yes No

Does your child take any bisphosphonate medications for bone disorders, such as Fosamax? Yes No

Please list and provide reasoning for any medications that are currently being taken:

Please list any allergies or drug sensitivity:

It is my understanding that the information I have given today is correct to the best of my knowledge. I am also aware that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I hereby authorize the staff at Buckhead Orthodontics to perform any necessary orthodontic services with my informed consent that I may need during diagnosis and treatment.

Signature: _____ Date: _____

Transfer Patients Only:

I hereby authorize the transfer of my orthodontic records to Michael B. Everson, DDS, MS.

Signature: _____

Date: _____