AmericanRiverOrthodontics.com

Child Patient Information Form

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Patient Name _____ Nickname _____

Address _____City _____ Zip _____

Age _____ Birth Date _____ Sex _____ School _____ Grade_____

Mother's Name _____ Employed by _____

Occupation _____

Home Phone _____ Cellular phone _____ Business phone _____

Father's Name _____ Employed by _____

Occupation_____

Home Phone _____ Cellular phone _____ Business phone _____

Alternate Address: _____City _____ Zip _____

If not married are the patient's parents…… □Divorced □Separated

If the parents live apart does the patient live with……□Mom □Dad □Other_____

Person Financially Responsible _____Relationship to patient _____

Address _____City _____ Zip _____Phone _____

Is the patient covered by insurance for orthodontic treatment? □Yes □No □Unknown

Primary Dental Carrier_____ Group # _____

Insured Name _____ Birth date _____ Soc.Sec.#_____

Secondary Dental Carrier _____ Group # _____

Secondary Insured Name_____ Birth date _____Soc.Sec.#_____

Do you anticipate a move or transfer in the near future □Yes □No

Names and ages of other children in the family: _____

Musical instruments played _____Sports _____ Hobbies _____

MEDICAL HISTORY

Patient's Physician _____
Patient's height _____Patient's Weight _____ Most recent physical examination_____
Any changes in health in the last year □Yes □No (If yes explain below) _____
Any operations, accidents, or hospitalizations? _____

List any medications, nutrient supplements or non prescription medicine taken now or in the past? □yes □no (If yes explain)

_____

List drug sensitivities, reactions to dental anesthetics, or any allergies _____

□ **yes** □ **no** Birth defects or hereditary problems?
□ **yes** □ **no** Rheumatoid or arthritic conditions?
□ **yes** □ **no** Endocrine or thyroid problems?
□ **yes** □ **no** Kidney problems?
□ **yes** □ **no** Diabetes?
□ **yes** □ **no** Cancer or treated for a tumor?
□ **yes** □ **no** Hepatitis, jaundice or liver problem?
□ **yes** □ **no** AIDS or HIV Positive?
□ **yes** □ **no** Fainting spells, seizures, epilepsy or neurological disease?
□ **yes** □ **no** Mental health or behavioral problems?
□ **yes** □ **no** Vision, hearing, tasting or speech difficulties?
□ **yes** □ **no** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
□ **yes**□ **no** High or low blood pressure?
□ **Yes** □ **no** Cardiovascular problems (heart trouble, stroke, heart defects or rheumatic heart)

□ **yes** □ **no** Eye, ear, nose, throat condition?
□ **yes** □ **no** Hay fever, asthma, sinus trouble, hives?
□ **yes** □ **no** Tonsil or adenoid conditions?
□ **yes** □ **no** Allergies or drug reactions?
□ **yes** □ **no** Substance abuse problem?
□ **yes** □ **no** Tuberculosis or communicable disease
□ **yes** □ **no** Other physical problems or symptoms?
□ **yes** □ **no** **Treatment for any conditions not listed above?**_____

Growth

Girls- Has she started menstruation?.....**Yes/No**
If yes, at what age? _____
□ **yes** □ **no** Pregnant or history of pregnancy
Boys- Has his voice changed?.....**Yes/No**
If yes, at what age? _____

Please describe any illnesses or conditions circled yes above including when contracted and whether currently under treatment as well as conditions not

listed above_____

Dental History

Dentist _____Date of most recent dental exam_____

How often does the patient see their dentist? Every…. □ 3 month's……..□ 6 month's……..…..□ 9 month's……□ 1 year

□ **yes** □ **no** Chipped or otherwise injured permanent teeth?
□ **yes** □ **no** History of decayed or abscessed teeth?
□ **yes** □ **no** Teeth sensitive to hot or cold; teeth throb or ache?
□ **yes** □ **no** **E**xtra or congenitally missing teeth?
□ **yes** □ **no** Jaw fractures, cysts, mouth infections?
□ **yes** □ **no** Cold sores, Canker sores, mouth ulcerations?
□ **yes** □ **no** Periodontal "Gum Problems", gum pocketing?
□ **yes** □ **no** Periodontal (gum) surgery treatment?
□ **yes** □ **no** **"TMJ"** (jaw joint) problems or facial muscle pain)?
□ **yes** □ **no** Tooth grinding, jaw clenching, clicking, locking?
□ **yes** □ **no** Difficulty chewing, jaw opening or closing with pain or noise?
□ **yes** □ **no** Mouth breathing habit, snoring, difficulty in
□ **yes** □ **no** Any history of speech problems?

	Yes	**No**
Have any teeth been removed by the dentist……	□	□
Thumb or finger sucking habit……	□	□
If yes at what age did they stop? _____		
Has an orthodontist been consulted previously……	□	□
Has the patient had any orthodontic treatment ……..	□	□

If yes please provide details _____

Dentist planning for……□ Fillings □ Crowns □ Implants □ Bridges □ gum treatment □ tooth extractions

Chief Complaint

Patients often need changes in their bites, appearance of teeth, or relationship of the teeth to the face. Please help us understand the patient's problem.

_____
_____
_____
_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that you feel might be encountered during treatment?_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.
We wish to inform you in advance that as part of our routine business procedure, our office contracts with Equifax to conduct a cursory credit history on the responsible party for each of our patients prior to treatment.

If there are any changes later to this child's medical/dental status, I will inform this practice.

Parent's Signature _____Date _____ Relationship to patient_____

Doctor's Signature _____Date _____

Review of medical and dental history

Changes □Yes □No If Yes describe_____

Parent's Signature _____Date _____ Doctor's Signature _____Date _____

Changes □Yes □No If Yes describe_____

Parent's Signature _____Date _____ Doctor's Signature _____Date _____