CHILD PATIENT INFORMATION

DATE________________

Name____ Date of Birth_____________
First M. Last

Name Patient Prefers to be Called ________________________________ Age ________ Sex ___________

Mailing Address____
Street City State Zip Code

Home Phone____ Email Address________________________

School______________________________ Grade______ Hobbies/Interests ____________________________

Names and ages of other children in family: ____

Patient's Dentist__________________________________ Date of last visit to dentist_______________

Whom may we thank for referring you?____

Have any Members of your Family been patients in our office? Yes/No ____________________________________
Name(s)

RESPONSIBLE PARTY INFORMATION

Father's Name _______________________________ Mother's Name _____________________________

Date of Birth ________________________________ Date of Birth _______________________________

Social Security # ______________________________ Social Security # ____________________________

Cell Phone __________________________________ Cell Phone ________________________________

Home Address ________________________________ Home Address ______________________________

____ ____

Occupation __________________________________ Occupation_________________________________

Employer ___________________________________ Employer __________________________________

Employer Phone _______________________________ Employer Phone _____________________________

Years Employed __________ Years Employed __________

Married _____ Divorced _____ Married _____ Divorced _____

Re-Married _____ Single _____ Re-Married _____ Single _____

Nearest Relative not living with You ____
Name Relationship Phone

MEDICAL HISTORY

Patient's Physician/Pediatrician ______________________________________

List any medicines your child is currently taking ____

List any drug sensitivity or allergies (including nickel) ____

Is there a history of serious illness, accident, or operation? ____

Has the patient reached puberty? Yes/No

Female: Has she started menstruation? Yes/No Month/Year _________ Male: Has voice changed? Yes/No

Please circle the following as they apply

Hepatitis	Bone Disorders	Frequent Sore Throats	Bleeding problems	Diabetes
AIDS/HIV	Tonsils/adenoids removed	Speech problems	Heart problems	Tuberculosis
Epilepsy	Rheumatic fever	Ear Infections/tubes	Mouth breathingADD/ADHD	
Arthritis	Kidney disease	Emotional problems	Hearing problems	

Other ____

DENTAL HISTORY

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

Does the patient clench or grind teeth? Yes/No Does the patient have jaw joint soreness or pain? Yes/No

Has the patient ever sucked a thumb or fingers? Yes/No Until what age? __________________________

Has the patient consulted with another orthodontist previously?_____________________________________

Has the patient had any previous orthodontic treatment?____

Primary reason for seeking orthodontic treatment____

Is the patient concerned about the appearance of the smile or teeth? ________________________________

Additional information which you feel would help make your child's association with us more enjoyable

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I certify that the above information is correct to the best of my knowledge. I authorize Dr. Dover to take x-rays and/or photographs as needed for diagnostic purposes.

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Signature of parent/guardian