ORTHODONTIC Arts

Child & Adolescent Patient Information Form

306 Brook Park Place
Forest, VA 24551
434-385-4499

Tell Us About Your Child

Today's Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Prefers to be Called: _____ Birthdate: _____ Age: _____ Sex: Male ☐ Female ☐

Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ School: _____ Grade: _____

Hobbies/sports: _____

General Information

Who is accompanying the child to the first visit? _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Other siblings/ages: _____ Names of family members treated here: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Whom may we thank for referring you? _____

Has your child had a previous orthodontic examination or treatment? ☐ Yes ☐ No

Name of Patient's Dentist: _____ Phone: (___)_____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician: _____ Phone: (___)_____

Date Last Seen: _____ Reason: _____

Parents' Information

Who is financially responsible for the account? _____
(If there is more than one responsible party and the parties are not married to each other, indicate the percentage that each will pay.)

Parents' Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Stepfather ☐ Guardian Title: ☐ Mr. ☐ Dr. ☐ Rev.

Name: _____ Birthdate: _____ SSN: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Email: _____

Street Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Father's Employer: _____ Occupation: _____ Work Phone: (_____)_____

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Insurance Co. Name: _____ Insurance Address: _____

Insurance Phone: (_____)_____ Insured's ID#: _____ Group #: _____

☐ **Mother** ☐ Stepmother ☐ Guardian Title: ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

Name: _____ Birthdate: _____ SSN: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email: _____

Street Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Mother's Employer: _____ Occupation: _____ Work Phone: (_____)_____

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Insurance Co. Name: _____ Insurance Address: _____

Insurance Phone: (_____)_____ Insured's ID#: _____ Group #: _____

Medical History

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

☐ yes ☐ no ☐dk/u Does patient follow directions well?

☐ yes ☐ no ☐dk/u Does patient brush his/her teeth conscientiously?

☐ yes ☐ no ☐dk/u Does patient have learning disabilities or need extra help with instructions?

☐ yes ☐ no ☐dk/u Is patient sensitive or self-conscious about teeth?

Now or in the past, has the patient had:

☐ yes ☐ no ☐dk/u Birth defects or hereditary problems?

☐ yes ☐ no ☐dk/u Rheumatoid or arthritic conditions?

☐ yes ☐ no ☐dk/u Endocrine or thyroid problems?

☐ yes ☐ no ☐dk/u Kidney problems?

☐ yes ☐ no ☐dk/u Diabetes?

☐ yes ☐ no ☐dk/u Cancer, tumor, radiation treatment, or chemotherapy?

☐ yes ☐ no ☐dk/u Stomach ulcer or hyperacidity?

☐ yes ☐ no ☐dk/u Polio, mononucleosis, tuberculosis or pneumonia?

☐ yes ☐ no ☐dk/u Problems of the immune system?

☐ yes ☐ no ☐dk/u AIDS or HIV positive?

☐ yes ☐ no ☐dk/u Hepatitis, jaundice or liver problems?

☐ yes ☐ no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?

☐ yes ☐ no ☐dk/u Mental health disturbance or behavioral problem?

☐ yes ☐ no ☐dk/u Vision, hearing, tasting or speech difficulties?

☐ yes ☐ no ☐dk/u History of eating disorder (anorexia, bulimia)?

☐ yes ☐ no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐ yes ☐ no ☐dk/u High or low blood pressure

☐ yes ☐ no ☐dk/u Chest pain, shortness of breath or swelling ankles?

☐ yes ☐ no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?

☐ yes ☐ no ☐dk/u Frequent headaches, colds or sore throats?

☐ yes ☐ no ☐dk/u Eye, ear, nose or throat condition?

☐ yes ☐ no ☐dk/u Hayfever, asthma, sinus trouble or hives?

☐ yes ☐ no ☐dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐dk/u Antibiotics (specify) _____

_____

☐ yes ☐ no ☐dk/u Other drugs (specify) _____

_____

☐ yes ☐ no ☐dk/u Nickel

☐ yes ☐ no ☐dk/u Latex (gloves, balloons)

☐ yes ☐ no ☐dk/u Other substances (specify) _____

☐ yes ☐ no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐ yes ☐ no ☐dk/u Does the patient currently have or ever had a substance abuse problem?

☐ yes ☐ no ☐dk/u Does the patient chew or smoke tobacco?

☐ yes ☐ no ☐dk/u Operations? Describe: _____

☐ yes ☐ no ☐dk/u Hospitalized? For: _____

☐ yes ☐ no ☐dk/u Other physical problems or symptoms?

Describe: _____

☐ yes ☐ no ☐dk/u Being treated by another health care professional?

For: _____

☐ yes ☐ no ☐dk/u Are there any other medical conditions that we should be aware of?

_____

Girls Only

☐ yes ☐ no ☐dk/u Has the patient started her monthly periods? If so, at what age? _____

☐ yes ☐ no ☐dk/u Is the patient pregnant?

Dental History

☐ yes ☐ no ☐dk/u Started teething very early or late?

☐ yes ☐ no ☐dk/u Primary (baby) teeth removed that were not loose?

☐ yes ☐ no ☐dk/u Any extra or missing permanent teeth? (specify which)

_____

☐ yes ☐ no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐dk/u Food impaction between teeth?

☐ yes ☐ no ☐dk/u Thumb, finger, or sucking habit? Until what age? _____

☐ yes ☐ no ☐dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐dk/u History of speech problems?

☐ yes ☐ no ☐dk/u Mouth breathing habit, snoring or difficulty breathing?

☐ yes ☐ no ☐dk/u Tooth grinding, jaw clenching, clicking or locking?

☐ yes ☐ no ☐dk/u Any pain in jaw or ringing in the ears?

☐ yes ☐ no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐dk/u Concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐dk/u Aware or concerned about under or over developed jaw?

☐ yes ☐ no ☐dk/u "Gum boils", frequent canker sores or cold sores?

☐ yes ☐ no ☐dk/u Taking any forms of fluoride?

☐ yes ☐ no ☐dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

☐ yes ☐ no ☐dk/u Any serious trouble associated with previous dental treatment?

☐ yes ☐ no ☐dk/u Been under another dental specialist's care?

☐ yes ☐ no ☐dk/u Is there anything you would like to discuss with the orthodontist in private?

How often does your child brush? _____ Floss? _____

What is your primary concern? Why are you here? _____

Authorization

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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I understand that Orthodontic Arts will assist me in filing claims for insurance benefits. I hereby authorize the orthodontist to release all information necessary to secure the payment of insurance benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that Orthodontic Arts does not take responsibility for the recovery of insurance benefits from my insurance carrier and that I am responsible for payment of all services rendered.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Doctor or Staff Member)