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Tell US ABOUT YOUR Today's Date:		_			
Child's Name:					_ (male/female)
Nickname:	Last	First	DOB:		
Home Tel #:			Email:		
Child's Home Address:					
	Street				
Town		State		Zip	
WHO IS WITH THE CH			Relation:		
Who may we thank for re	eferring you?				
Other family members se	en by us:				
General Dentist:					
Street			Town		Zip
Tel #:			Last Visit:		
Parent's Marital	Status: single	married divor	rced		
MOTHER'S INFORMAT					
Name:		_	Tel#:		
Cell #:	Employer:		Work tel #:		
FATHER'S INFORMATINAME:		_	Tel#:		
Cell #:	Employer:		Work tel #:		
RESPONSIBLE PARTY Name:	INFORMATION:		Tel#:		
Billing Address:					
Cell #:	Street Employer:		Town Work tel #:		Zip ————
PRIMARY DENTAL INS Orthodontic Coverage:		Insurance Co.:_			
Ins. Address:					
Ins. Co. Tel #:	Street	Group/	Town Policy #:		Zip ————
Insured's Name:		Subscri	ber ID# or SS#:		
Relation to Patient:		Insured	l's DOB:		
Secondary Insurance:					



Signature of parent/guardian

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT FOR YOUR CHILD?:

Has the child ever had a serious/o	difficult	problem a	ssociated with de	ental work?	Υ	N
Is the child's water fluoridated?	ents? Y	N				
Has the child ever had any pain o	Υ	N				
Does the child brush daily?	Y/N	Child	's Physician:			
Tel #:			Last Visit:			
Please describe the child's hea	alth:	Good	l Fair	Poor		
Please list all drugs the child is	s currer	ntly taking	g:			
Please list all drugs the child is	allergi	ic to:				
HAS THE CHILD EVER HAD AN	IY OF T	HE FOLL	OWING MEDIC	CAL PROBLEMS	5 ?:	
Heart Murm. Cancer Diabetes Rheum. Fev. HIV +/ AIDS Hemophilia Asthma Hepatitis Tuberculosis Prosthesis Please discuss any serious medica	Y Y Y Y Y Y Y Y	N N N N N N N N N	Congenital He Convulsions/I Abnormal Ble Hearing Impa Any Operatio Any Stays in Kidney/Liver Handicaps/Di Allergies to A History of Sca	Epilepsy seding sirment ns Hospital Problems isabilities ny Drugs arlet Fever	Y Y Y Y Y Y Y	N N N N N N N N N N N N N N N N N N N
DOES THE CHILD HAVE ANY O)F THE	FOLLOW	ING HABITS?:			
Thumb/Finger Sucking Nail Biting	Y Y	N N	Lip sucking/b Nursing Bottle		Y Y	N N
Our office is committed to meetin CDC, and the ADA. I understand the information will be held in the strictest co changes in my child's medical dental services my child may	that I infidence	have give ce, and it s. I also a	en is correct to t is my respons authorize the d	the best of my	y knowled m this offic	ge, that it ce of any

Date