New Patient Information (Child)

Patient Information

Today's Date ________________ Male ☐ Female ☐ Age _____ Birthdate ____/____/______
Name ____ Nick Name _________________________
Address (Street, City, State, Zip) ____
Home phone _________________________ Cell phone ___________________________
E-mail ____
Siblings (name and age) ____
Height __________ Weight __________
Medical Condition ____
Medication _______________________________ Allergy _________________________________
General dentist _____________________________ Last dental exam _______________________
Prior orthodontic treatment: Yes ☐ No ☐ If yes, when ________________________
Previous injury to face, mouth, teeth, or chin: Yes ☐ No ☐ If yes, when ________________________
What are your concerns about the smile?
Overbite ☐ Under bite (crossbite) ☐ Crowding ☐ Spacing ☐ Other ___________________
Habit: Thumb sucking ☐ Mouth breathing ☐ Grinding ☐ Clenching ☐ Other _________________
Sports: _________________________________ Musical instruments: _____________________________
Emergency contact _________________________ Phone __________________ Relationship ___________

How did you hear about our office?
Referral ☐ (Name ________________________________) Internet ☐ Sign ☐ Yellow Page ☐

Parent Information

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

Father

Is he responsible for payment? Yes ☐ No ☐
Name ____ Birthdate ____/____/______
Address (Street, City, State, Zip) ____
Home phone _____________________ Cell phone _____________________ SS # _____________________
E-mail ____
Employer _________________________________ Work phone ______________________
Orthodontic insurance: Yes ☐ No ☐ Company name ___________________________________

Mother

Is she responsible for payment? Yes ☐ No ☐
Name ____ Birthdate ____/____/______
Address (Street, City, State, Zip) ____
Home phone _____________________ Cell phone _____________________ SS # _____________________
E-mail ____
Employer _________________________________ Work phone ______________________
Orthodontic insurance: Yes ☐ No ☐ Company name ___________________________________