nirenblatt
ORTHODONTICS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date ____________________

Patient's name ____________________
Last First Middle

Address ____________________
Street City Zip

Nickname ________ Birthdate ________ Social Security # ________

School ________ Sports / Hobbies ________

Parent or guardian name ____________________

How have you heard of our office? Please check all that apply: ◯ Friend Friend's Name: ____________________

◯ Internet ◯ Your Dentist ◯ Family Member ◯ Facebook ◯ Direct Mail ◯ Drive By Sign

◯ Television ◯ Previous Patient ◯ Insurance Plan ◯ Radio ◯ Staff Member ◯ School

RESPONSIBLE PARTY INFORMATION

Name ____________________

Mailing Address ____________________

How long at this address? ________ Home Phone ________ Work Phone ________

Cell / other phone ________ Email address ________

Social Security # ________ Birthdate ________ Relationship to patient ________

Are you employed? Yes or No ________ Employers name or source of income ________ No. years employed ________

Spouse's Name ________ Relationship to patient ________

Is spouse employed? Yes or No ________ Employers name or source of income ________ No. years employed ________

DENTAL INSURANCE INFORMATION

Insured's Name ________ Birthdate ________ Insured's Social Security # ________

Insurance Company ________ Group# ________ ID# ________

Insurance Co. Address ________ Phone No. ________

Do you have dual coverage? Yes No If yes: ________

Insured's Name ________ Birthdate ________ Insured's Social Security # ________

Insurance Company ________ Group# ________ ID# ________

Insurance Co. Address ________ Phone No. ________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____________________

Complete address ____________________

Phone ____________________

AGREEMENT

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

____
Signature of parent/patient/guardian

____
Date

FOR OFFICE USE ONLY

Date: ________ Date: ________

Reviewed by: ________ Reviewed by: ________

Doctor's notes: ________ Doctor's notes: ________

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CHILD UNDER 18 PATIENT MEDICAL HISTORY INFORMATION

Physician ______ Date of Last Visit ______

Address ______ Phone ______

List all medications your child is taking: ______

List any allergies your child has: ______

Yes No Do you have a history of a major illness?

Yes No Have you had any operations?

Yes No Have you ever been involved in a serious accident?

Yes No Have you ever smoked or chewed tobacco?

Yes No Have you seen a physician in the last 12 months? Why?

Yes No Female patients only: Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/hemophilia
Addiction
Anemia
Anxiety
Arthritis
Artificial Joints
Asthma or Hayfever
Bone Disorders
Congenital Heart Defect
Diabetes
Dizziness
Epilepsy
Gastrointestinal Disorders
Heart Murmur
Heart Problems
Hepititis/Liver problems
Herpes
High Blood Pressure
HIV / AIDS
Kidney Problems
Neurological Condition
Psychological Condition
Radiation/Chemotherapy
Rheumatic Fever
Tuberculosis
Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ______

DENTAL HISTORY CHILD UNDER 18

Name of Dentist: ______ When was your last cleaning? ______

Yes No Are you presently in dental pain?

Yes No Have you ever experienced any unfavorable reaction to dentistry?

Yes No Have your wisdom teeth been removed?

Yes No Have you ever lost or chipped any teeth?

Yes No Have there been any injuries to face, mouth, or teeth?

Yes No Is any part of your mouth sensitive to temperature? Where?

Yes No Is any part of your mouth sensitive to pressure? Where?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb habit?

Yes No Do you have a tongue habit?

Yes No Are you a mouth breather? Do you snore heavily?

Yes No Have you ever seen an orthodontist? If yes, who and when?

Yes No What is your attitude toward receiving orthodontic treatment?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Does your jaw click or pop?

Yes No Do you grind or clench your teeth?

Yes No Do you have difficulty opening your mouth?

Yes No Do you have frequent headaches?

What would you like to change about your child's smile? ______