Dr. _____

Recs. _____ _____
Date Time

X-Ray _____ _____
Date Time

Child Form

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Orthodontic Specialists

www.webbraces.com
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A	B	C

Report Date: _____

1st EXAM

Month	Day	Year

RE-CALL

Month	Day	Year

RE-CALL

Month	Day	Year

1 | Tell us about your child

Child's Name _____ _____
Last First Middle Preferred Name

❑ Male ❑ Female Birth Date: _____ Age: _____

Address: _____ How long at this Address: _____
City Zip

Home Phone: (____) _____ Hobbies: _____

School: _____ Grade: _____

Patient or Parent E-Mail: _____ Family in treatment with us: _____

List brothers/sisters and their ages: _____

Whom may we thank for referring you? _____

2 | General Dentist: _____ Last visit date: _____

Address: _____ Phone #: (____) _____

3 | Mother's Information Responsible Party: ___ Yes ___ No

Name _____ ❑ Step mother ❑ Guardian Birth Date: _____

Work Phone #: (____) _____ Home Phone #: (____) _____

Employer: _____ Job Title: _____

How long at current job: _____ SS#: _____ DL#: _____

4 | Father's Information Responsible Party: ___ Yes ___ No

Name _____ ❑ Step father ❑ Guardian Birth Date: _____

Work Phone #: (____) _____ Home Phone #: (____) _____

Employer: _____ Job Title: _____

How long at current job: _____ SS#: _____ DL#: _____

5 | Parent(s) Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Person (NOT living with you) to contact in case of emergency:

Name: _____ Relationship: _____ Phone #: (____) _____

6 | Primary Orthodontic Insurance

Insurance Co. name: _____
Policy owner's name: _____
Policy owner's birthdate: _____
Policy owner's SS#: _____

7 | Secondary Orthodontic Insurance

Insurance Co. name: _____
Policy owner's name: _____
Policy owner's birthdate: _____
Policy owner's SS#: _____

8 | Dental History

Any injuries to head or mouth? _____ Any jaw clicking, locking or pain? _____

Has child ever had orthodontic treatment or worn a retainer or bite plate: **Y** or **N**

Has either parent had orthodontic treatment? **Y** or **N** Who: _____ When: _____

Please check YES or NO to any of the following conditions that apply to your child:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
❑	❑	Baby teeth removed	❑	❑	Frequent Cold Sores, Canker Sores	❑	❑	Root Canals
❑	❑	Chipped / Injured Teeth	❑	❑	Grinding Teeth or Clenching	❑	❑	Sensitivity to Cold / Heat
❑	❑	Cyst / Infection	❑	❑	Jaw Fractures	❑	❑	Teeth Irritating Cheek / Lips
❑	❑	Dental Treatment in Progress	❑	❑	Missing Teeth	❑	❑	Thumb Habit To Age _____
❑	❑	Difficulty Breathing / Chewing	❑	❑	Mouth Breathing	❑	❑	Tongue Habit
❑	❑	Food Impaction	❑	❑	Periodontal Problems / Bleeding Gums	❑	❑	Any Permanent or Extra Teeth Removal

9 | Medical History

Physician _____ Phone #: _____ Last visit: _____

Please list all medications your child is currently taking (or has taken in the past 2 years): _____

_____

Are there any psychological or emotional problems that should be brought to our attention: _____

Does your child need to be pre-medicated: **Y** or **N** Why: _____

(Females) Is the patient: Taking birth control pills? **Y** or **N** Pregnant?: **Y** or **N** Nursing?: **Y** or **N**

Allergies: _____ Medical Insurance: _____
(Foods / Medications / Latex Gloves / Unknown ...)

Has your child ever been hospitalized? **Y** or **N** Explain: _____

Please check YES or NO to any of the following conditions that apply to your child:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
❑	❑	Is child in general good health?	❑	❑	Chemical Dependency	❑	❑	Hemophilia	❑	❑	Radiation Treatment
❑	❑	Accidents	❑	❑	Chemotherapy	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Disease
❑	❑	ADD / ADHD	❑	❑	Circulatory Problems	❑	❑	High or Low Blood Pressure	❑	❑	Rheumatic Fever
❑	❑	Anemia	❑	❑	Diabetes / Blood Sugar	❑	❑	HIV Positive / AIDS	❑	❑	Scarlet Fever
❑	❑	Arthritis, Rheumatism	❑	❑	Epilepsy	❑	❑	Jaw Pain	❑	❑	Severe Infections
❑	❑	Artificial Heart Valves	❑	❑	Fainting-Seizures-Convulsions	❑	❑	Kidney or Bladder	❑	❑	Shortness of Breath
❑	❑	Artificial Joints	❑	❑	Glandular/Hormonal Problems	❑	❑	Liver Disease	❑	❑	Speech / Learning Disorder
❑	❑	Asthma or Hay Fever	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke
❑	❑	Autism	❑	❑	Headaches - Migraines	❑	❑	Nervous / Hyperactive	❑	❑	Thyroid Problems
❑	❑	Back Problems	❑	❑	Hearing Loss	❑	❑	Polio / Mono / Pneumonia	❑	❑	Tobacco Habit
❑	❑	Blood Disease	❑	❑	Heart Murmur	❑	❑	Prolonged Bleeding	❑	❑	Tuberculosis
❑	❑	Bruises Easily	❑	❑	Heart Problems	❑	❑		❑	❑	Ulcer
❑	❑	Cancer	Describe: _____						❑	❑	Venereal Disease

10 | Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand that, if necessary, credit bureau reports may be obtained.

It is my responsibility to advise the office of any changes in personal/medical status: Parent's Initials _____

Please sign that this information is accurate and complete:

Signature _____ Relationship _____ Date _____

Received by Dr. _____ Date _____

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? **Y** or **N**