3 MEDICAL AND DENTAL HISTORY

Please circle Y or N for each question

Y N Has patient had tonsils and adenoids removed? When?

Y N Does patient have any endocrine (hormone) disturbances? (eg. diabetes, thyroid, etc.)

Y N Does patient bleed for a prolonged period when cut or after tooth extractions?

Y N Does patient have any heart, lung, kidney or digestive tract problems? Which?

Y N Is patient taking any medications now? Please list.

Y N Is patient allergic to any medications? Please list.

Y N Is patient allergic to any metals or latex? Which?

Y N Does patient suffer from asthma or bronchitis?

Y N Has patient ever had seizures? Medications?

Y N Has patient ever been under the care of a physician for illness? Please list.

Y N Has the patient reached puberty? (girls-started menstruation? boys-voice changed?)

Y N Has patient ever had rheumatic fever?

Y N Has patient ever had a positive test for HIV, AIDS, or Hepatitis?

Y N Is the patient adopted?

Y N Do you believe the patient's problem is inherited?

Y N Have any teeth been extracted from the patient's mouth?

Y N Are you aware of any missing or extra teeth?

Y N Has patient ever sucked a finger, thumb or pacifier? If so, which? When did the patient stop?

Y N Has patient ever suffered any injury to the face? What and when?

Y N Have any teeth been injured due to an accident or fall?

Y N Is patient apprehensive toward dental visits?

Y N Does patient play a musical instrument with the mouth? Which instrument?

Y N Is patient willing to wear braces if needed?

Y N Does patient's jaw ever pop or make noise? (if so, please ask to fill out an additional information sheet)

What do you feel are the main problems with the teeth and/or bite?

How do you feel orthodontics can help?

4

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I give permission to use my child's photo for the office website, facebook page, bulletin boards, etc.
I ALSO give permission for Innovative Orthodontics to give automated appointment reminder phone calls.

X SIGNATURE Date:

OFFICE USE ONLY

CHILD FORM

INNOVATIVE Orthodontics SETTIN' TEETH STRAIGHT

Please use Black or Blue ink when filling out this form.

OUR MISSION STATEMENT

Our team is dedicated to providing excellent service and top quality treatment results in a caring, hospitable and safe environment while enhancing self-esteem by producing beautiful smiles for our patients.

1 ABOUT YOUR CHILD

Patient's name	Nickname	Sex	
Address	City	State	Zip
Home Phone	Patient Cell Phone	Patient's dentist	
Birthdate Age	School	Grade	
Special interests, sports or hobbies?			
Siblings' names and ages			
Have we seen any family member before? Y N	If so, patient's name		
How did you hear about our office?			

Father's name	Email		
SS#	Birthdate	Cell Phone	
Address	City	State	Zip
Step Mother's Name	Birthdate	SS#	
How long at this address	Martial Status: Married	Divorced	Single
Employer	Address	Work Phone	
Occupation	Years Employed		
Does the father/step mother have orthodontic insurance? Y N	Insurance Company Name		
Address	Insurance Phone		
I.D.#	Group #	LTM$	

Mother's name	Email		
SS#	Birthdate	Cell Phone	
Address	City	State	Zip
Step Father's Name	Birthdate	SS#	
How long at this address	Martial Status: Married	Divorced	Single
Employer	Address	Work Phone	
Occupation	Years Employed		
Does the mother/step father have orthodontic insurance? Y N	Insurance Company Name		
Address	Insurance Phone		
I.D.#	Group #	LTM$	

2 ACCOUNT RESPONSIBILITY

Person responsible for account	Address
If parents are divorced, who has legal custody of patient (if minor?)	

I acknowledge that where appropriate a Credit Bureau report may be obtained.

X SIGNATURE Date:

Thank you for taking the time to fill out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. (573) 332-7223