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NEW PATIENT INFORMATION CHILD

Today's Date: _____

Child's Name _____ Nickname _____
LAST FIRST MI

Home Address _____

Phone _____ School _____ Grade _____

Contact email _____

Date of Birth _____ Age _____ Sex: Female Male

List Sports & Interest of Patient _____

Patient's Dentist _____ Last visit date _____

Referred by _____

Patient Lives with: both parents mother father guardian

Father's Name _____ Employment _____

Work Phone _____

Mother's Name _____ Employment _____

Work Phone _____

Marital Status: married separated divorced remarried widowed single

Name & Ages of Children in family _____

Main concern(s) for today's appointment: _____

Does the patient want orthodontic treatment? _____

MEDICAL HISTORY

Diabetes	Y	N	Hay Fever	Y	N	HIV	Y	N
Heart Trouble	Y	N	Asthma	Y	N	Tonsillitis	Y	N
Rheumatic fever	Y	N	Allergies	Y	N	Hepatitis	Y	N
Bone disorders	Y	N	Convulsions	Y	N	Endocrine-thyroid	Y	N
Abnormal bleeding	Y	N	ADD/ADHD	Y	N	Epilepsy	Y	N

Any other medical concerns?

List any drugs or medications currently taking:
_____ Why? _____
_____ Why? _____

Is the patient allergic to any medications? _____

Is the patient allergic to? LATEX METALS/NICKEL PLASTICS

Have tonsils and adenoids been removed? _____ Does patient snore? _____

Has the patient reached puberty? _____ Patient most resembles: Mother Father Both

Height: Patient _____ Mother _____ Father _____

Have there been any injuries to the face, mouth or teeth? _____
 Did the patient ever suck thumb or fingers? _____ Until what age? _____
 Does the patient have any problems with speech? _____
 Does the patient play a wind musical instrument? _____ What kind? _____
 Have you been informed of any missing or extra permanent teeth? _____
 Has the patient had any previous orthodontic examinations? _____
 Where any x-rays taken? _____
 Is the patient especially apprehensive towards dental visits? _____
 Does the patient have any congenital abnormalities? _____
 Does the patient have any of the following habits? MOUTH BREATHER NAIL BITING
 NURSING/BOTTLE HABITS LIP SUCKING/ BITING TONGUE THRUST

TMJ HISTORY

Has the patient had any discomfort or clicking in the jaw-joints near the ears? _____
 Does the patient clench or grind his/her teeth? _____
 Does the patient have frequent head or neck aches? _____
 Does the patient have pain or ringing in the ears? _____
 Has the patient's jaw ever locked or slipped out of place? _____
 Are his/her teeth sore or sensitive? _____

INSURANCE INFORMATION

Person Responsible for Account _____
LAST FIRST MI
 Relationship to Patient _____ Date of Birth _____
 Address (if different than patient) _____
 Home Phone _____ SS # _____
 Employer _____ Occupation _____
 Business Address _____ Business Phone _____
 Insurance Company _____ Insurance Phone _____
 Insurance Company Address _____

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

 Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

 Signature of parent or guardian Date

Doctor/Staff Signature _____ Date _____
 Nick Ridder, DDS, MS