primeorthodontics
for children and adults

For Child

Thank you for completing the information below.

The information in this history form will help us provide the best care and service

Patient Information - Child

Patient's Name_____
First Middle Last

Nickname (if preferred)_____

Age_____ Birthdate ____-____-____ M[ ] F[ ] F SS#_____-_____-_____

Home Address_____

Email_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

Person Responsible For Account

Parent/Guardian's Name_____ DOB____-____-____

Relationship_____ Email_____ SS#_____-_____-_____

Billing Address_____ Home Phone_____-_____-_____

Work Phone_____-_____-_____ Occupation_____ Employer_____

Insurance Information

Dental Insurance Company Name_____

Insurance Phone_____-_____-_____ Insured's Name_____

DOB____-____-____ Insured's SS#_____-_____-_____ Relationship_____

Group Number_____ Policy Number_____

Employer and Address_____

_____

Medical History

Physician's Name_____ Phone_____-_____-_____

Yes No

[ ] [ ] Is the patient taking any pills, medications, or drugs?
[ ] [ ] Does the patient have any allergies or unusual reaction to any medications?

List Medications_____

Are there any medical problems the patient has and the doctor should be aware of?

_____

Dental History

Dentist's Name_____ Phone_____-_____-_____

What is the major concern about the patient's teeth?

_____

Frequency of Dental Checkup/Cleaning_____

Date of Last Checkup/Cleaning____-____-____

Yes No

[ ] [ ] Has the patient had a previous orthodontic consultation of treatment?
[ ] [ ] Has any family member had orthodontic treatment? If so, Who?_____
[ ] [ ] Does the patient have pain or clicking of the jaw joint?
[ ] [ ] Does the patient grind or clench their teeth?
[ ] [ ] Does the patient ever have pains in the face or head?
[ ] [ ] Has the patient ever had severe jaw or head injury?
[ ] [ ] Does the patient snore?

Are there any other dental/orthodontic problems that the doctor should be aware of?

_____

How did you hear about us?_____

I understand that the information that I have provided 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 medical status.

Parent/Guardian Signature_____**Date**____-____-____