CURTIS ORTHO

Today's date: _____ Child's name: _____

Nickname: _____ Date of birth: _____ Sex: Male or Female

Address:_____

City:_____ State: _____ Zip: _____

Home#: _____ Name of school: _____

Are mother and father divorced or live in separate households? Yes or No

PARENT INFORMATION:

Father's name: _____ Date of birth: _____

Email address:_____ Mobile#: _____

Address if different from patients:_____

Mother's name:_____ Date of birth: _____

Email address:_____ Mobile#: _____

Address if different from patients:_____

PRIMARY INSURANCE:

Insured Person's Name: _____ Date of Birth: _____

Employer Name: _____

Name of Insurance: _____ SSN: _____

Insurance ID#_____ Group#_____

SECONDARY INSURANCE:

Insured Person's Name: _____ Date of Birth: _____

Employer Name: _____

Name of Insurance: _____ SSN: _____

Insurance ID#_____ Group#_____

DENTAL HISTORY:

Dentist's name: _____

Your child's last exam and cleaning was? _____

1.) Do your child's gums bleed when brushing? Yes or No

2.) Has your child ever been told that they have gingivitis? Yes or No

3.) Does your child have any clicking, popping or pain in the jaw joint? Yes or No

4.) Does your child clench or grind their teeth? Yes or No

5.) Does your child have any problems opening or closing their mouth? Yes or No

6.) Has your child ever injured or had trauma to their teeth, face or jaw? Yes or No If yes, please explain: _____

7.) Has your child had prior orthodontic treatment in the past? Yes or No If yes, do they have a retainer that they are still wearing? Yes or No

8.) Has your child ever been advised by their physician to take an antibiotic prior to dental treatment? Yes or No If yes, please explain: _____

9.) Is there any dental work in progress or that needs to be completed? Yes or No

10.) What is your main concern about your child's teeth? _____

_____

MEDICAL HISTORY:

Physician's name: _____

1.) Does your child have health problems, disorders or conditions? Yes or No If yes explain: _____

2.) Does your child have any allergies to medications? Yes or No If yes, please list:

_____

4.) Allergic to LATEX? Yes or No Environmental: (Dust, Pollen, or Mold) Yes or No

5.) Medications that they are CURRENTLY taking: _____

_____

6.) Is it okay to discuss your child's facial appearance, extractions, appliances, treatment and etc. while present? Yes or No (If no, we will excuse your child with your consent.)

7) Does your child suck their fingers or thumb? Yes or No

8) Did they suck their fingers or thumb in the past? Yes or No If yes, how long ago did they stop? _____

CHILD'S HEATH HISTORY:

Birth Problems……..	Yes or No	Emotional or Behavior Problems….	Yes or No
Speech Problems…….	Yes or No	Hearing Problems……..	Yes or No
Tonsils/Adenoids Problems.	Yes or No	Growth Problems……	Yes or No
Attention Deficit Disorder…	Yes or No	Heart Murmur……..	Yes or No
Diabetes…….	Yes or No	Rheumatic Fever……..	Yes or No
Arthritis……	Yes or No	Anemia…….	Yes or No
Cancer……	Yes or No	Radiation Therapy……	Yes or No
Sickle Cell Anemia…….	Yes or No	Cerebral Palsy……..	Yes or No
Bleeding or Hemophilia……	Yes or No	Seizures……..	Yes or No
Blood Transfusions……	Yes or No	Asthma…….	Yes or No
Hepatitis……..	Yes or No	Cleft Lip or Palate……	Yes or No
AIDS or HIV+……	Yes or No	Eye Problems……	Yes or No
Tuberculosis……....	Yes or No	Liver Disease……	Yes or No
Sleep Apnea……..	Yes or No	Kidney Disease……	Yes or No
Osteoporosis……..	Yes or No	Skin Problems……	Yes or No

Whom do we thank for referring your child to our office?_____