

# MIDDLETON ORTHODONTICS

*In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.*

## CHILD PATIENT INFORMATION

Patient's Name (First, Middle, Last) \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Nickname (if preferred) \_\_\_\_\_  Male  Female Patient's Home Phone \_\_\_\_\_

Patient's Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Siblings (Name, Age) \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Have we treated another member of your family?  Yes  No If YES, Name (First, Last) \_\_\_\_\_

Has your child visited an orthodontist before or had any previous treatment?  Yes  No If Yes, please explain? \_\_\_\_\_

## PARENTS/GUARDIAN INFORMATION

**Patient Lives With:**  Father  Mother  Step-Father  Step-mother  Grandfather  Grandmother  Aunt  Uncle  Guardian  Other

Name (First, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Name (First, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

***If you have insurance coverage for the child, please fill out.***

Insured Name (First, Last) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you (First, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_ Phone # \_\_\_\_\_

**DENTAL HISTORY**

Patient's General Dentist Name \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Dentist address \_\_\_\_\_ Phone number \_\_\_\_\_

Does the child require pre-medication antibiotics before dental treatment?  Yes  No If Yes, explain \_\_\_\_\_

Have the adenoids or tonsils been removed?  Yes  No Have you been informed of any missing or extra permanent teeth?  Yes  No

Any injuries to the child's face, mouth or chin?  Yes  No Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)?  Yes  No

Does the child play a musical instrument?  Yes  No If Yes, what kind? \_\_\_\_\_

Does/Did the child have any of the following?

- |   |   |  |
|---|---|--|
| <input type="radio"/> Unfavorable Dental experience | <input type="radio"/> Clenching or Grinding | <input type="radio"/> Finger/Thumb Sucking |
| <input type="radio"/> Prolonged Bottle/Pacifier     | <input type="radio"/> Mouth Breathing       | <input type="radio"/> Speech Problems      |
| <input type="radio"/> Chewing/Eating Problems       | <input type="radio"/> Tongue Thrust         | <input type="radio"/> Teeth sensitivity    |

**MEDICAL HISTORY**

Is the child currently under the care of a physician?  Yes  No If Yes, for what reason? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone number \_\_\_\_\_

History of any major illness?  Yes  No If Yes, please describe \_\_\_\_\_

Is the child allergic to Laxtex?  Yes  No Any other allergies?  Yes  No If Yes, please list: \_\_\_\_\_

Currently taking any medication?  Yes  No If Yes, please list: \_\_\_\_\_

Has the child been treated for any of the following?

- |  |   |  |                                    |
|--|---|--|------------------------------------|
| <input type="radio"/> Arthritis                | <input type="radio"/> Asthma                | <input type="radio"/> Blood Disorder   | <input type="radio"/> Cancer       |
| <input type="radio"/> Diabetes                 | <input type="radio"/> Epilepsy/Seizures     | <input type="radio"/> Heart Condition  | <input type="radio"/> HIV/AIDS     |
| <input type="radio"/> Liver problems/Hepatitis | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Nervous Disorder | <input type="radio"/> Tuberculosis |

Please describe any current medical treatment including any medications not mentioned above: \_\_\_\_\_

**SIGNATURE**

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 child's medical status.

Signature of Responsible Party: \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_