



## Patient Information

Today's Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Nick name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Hobbies/Interests \_\_\_\_\_  
General/Pediatric Dentist \_\_\_\_\_ City \_\_\_\_\_ Last Visit \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Siblings: Name/Age \_\_\_\_\_

## Responsible Party Information

Father's Name \_\_\_\_\_  Biological  Other \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ How Long? \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Mother's Name \_\_\_\_\_  Biological  Other \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ How Long? \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Person financially responsible for this account \_\_\_\_\_

## Orthodontic Insurance Information

*Primary Dental Insurance* Orthodontic Coverage  Yes  No  
Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_ Employer \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance IDN \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_  
Do you have dual coverage?  Yes?  No  
*Secondary Dental Insurance* Orthodontic Coverage? Yes  No  
Insured's Name \_\_\_\_\_ Relation: \_\_\_\_\_ Employer: \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance IDN \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_

## Emergency Information

Contact Person \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Last Visit \_\_\_\_\_ Phone Number \_\_\_\_\_

Current physical condition  Good  Fair ? Poor      Currently under the care of a physician?  Yes  No

Ever been under the care of a physician for a major illness?  Yes  No \_\_\_\_\_

**Please answer all questions by checking 'Yes' or 'No'.**

Good Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent cold, cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever, seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nasal obstruction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes (cold sores)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Growth disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Canker Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsils/Adenoids removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotics required for	
Still Growing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any drugs (prescription and over the counter) that currently taking and please give reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies or sensitivities including drug, latex metal or other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has patient reached puberty?  Girl – Started Menstruation  Yes  No \_\_\_\_\_

Boy – Voice Changed/Facial hair  Yes  No \_\_\_\_\_

## Dental History

What is the main concern you would like orthodontics to accomplish? \_\_\_\_\_  
\_\_\_\_\_

Current Dental Health  Good  Fair  Poor

Has an orthodontist been consulted previously?  Yes  No Have you ever been treated with orthodontics before?  Yes  No If yes, please explain: \_\_\_\_\_

Family history of orthodontic treatment  Yes  No \_\_\_\_\_

Has the patient ever sucked a thumb or finger?  Yes  No If yes, until what age? \_\_\_\_\_

Has your child ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?  Yes  No

Does your child have a tongue thrust?  Yes  No Any history of speech problems?  Yes  No

Has your child ever had injuries to your face, mouth, teeth or chin?  Yes  No

Does your child generally breath through their mouth? Awake:  Yes  No Asleep  Yes  No

Does your child have any missing or extra permanent teeth?  Yes  No \_\_\_\_\_

I have read and understand the above questions. I will not hold Dr. Washington or any member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PRINT**