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Parkside
Orthodontics

Appointment _____

CHILD'S INFORMATION

Name _____ Preferred Name _____
(Last) (First) (MI)
Sex _____ Age _____ Birth Date ____/____/_____ School _____ Grade _____

Hobbies / Interests _____

Reason for orthodontic consultation _____

Have any family members been to our office before? ❑ Yes ❑ No Who? _____

How did you learn about our office? _____

The child's interest in having treatment is ❑ Excited ❑ Nervous ❑ Other _____

PARENT'S INFORMATION

Name _____
Relationship to Child _____
❑ Responsible for account
Address _____
City _____ Zipcode _____
Length of residence _____
Child lives at above address ❑ Full-time ❑ Part-time
Home Phone _____
Cell Phone _____
Work Phone _____
Employer _____
Occupation _____
Length of employment _____
DOB _____ Marital Status _____
SS# _____
Email _____

Name _____
Relationship to Child _____
❑ Responsible for account
Address _____
City _____ Zipcode _____
Length of residence _____
Child lives at above address ❑ Full-time ❑ Part-time
Home Phone _____
Cell Phone _____
Work Phone _____
Employer _____
Occupation _____
Length of employment _____
DOB _____ Marital Status _____
SS# _____
Email _____

DENTAL INSURANCE INFORMATION

Please bring your dental insurance cards, or complete the following information:

Subscriber _____ DOB _____
SS # / ID # _____
Insurance Company _____
Telephone _____
Group# _____

Subscriber _____ DOB _____
SS # / ID # _____
Insurance Company _____
Telephone _____
Group# _____

DENTAL HISTORY

Dentist_____ Date of last dental cleaning _____

Pending dental treatment_____

Has there been previous orthodontic treatment? ❑ **Yes** ❑ **No** If yes, please explain _____

_____

Has there been an orthodontic consultation for the current concern? ❑ **Yes** ❑ **No**_____

Has another member of the family had orthodontic treatment? ❑ **Yes** ❑ **No** Who? _____

Is child related to anyone that has/had: ❑ Missing Adult Teeth ❑ Impacted Teeth (not wisdom)

❑ Underbite ❑ Small Teeth

MEDICAL HISTORY

Primary physician _____ Phone_____

Is the child taking any medicine at this time? ❑ **Yes** ❑ **No** Specify _____

Does the child have any allergies? ❑ **Yes** ❑ **No** Specify_____

Does the child need antibiotics before certain dental procedures? ❑ **Yes** ❑ **No**_____

If yes, please specify and give reason for this need_____

Does the child have (or had) any of the following? ____ NONE

❑ AIDS/HIV+	❑ Arthritis	❑ Rheumatic Fever
❑ Bleeding Disorders	❑ Hearing Problem	❑ Speech Therapy
❑ Epilepsy/Seizures	❑ Injury to Head/Face/Teeth	❑ Lung Disease
❑ Behavioral Condition	❑ Radiation or Cancer Therapy	❑ Females Only: Pregnant
❑ Unfavorable Dental Experience	❑ Asthma	❑ Diabetes
❑ Anemia	❑ Cold Sores	❑ Oral Ulcers
❑ Birth Defects	❑ Heart Condition	❑ Tonsils/Adenoids surgery
❑ Diabetes	❑ Kidney Disease	❑ Hepatitis Type_____

ADDITIONAL MEDICAL INFORMATION _____

_____

HABITS Does the child suck thumb, finger, pacifier, etc? ❑ **Yes** ❑ **No**, stopped at age _____ ❑ Never

GROWTH STATUS Is child developing: ❑ Early ❑ Average ❑ Late

FEMALES Has the child started her menstruation? ❑ **Yes** ❑ **No** If yes, at what age? _____

MALES Has the child undergone voice changes? ❑ **Yes** ❑ **No** Facial hair growth? ❑ **Yes** ❑ **No**

Signature _____ Relationship to the child _____Date _____

☺ Thank you for your help! We're excited to get to know your family! ☺

Member American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Future medical/dental updates:

Date _____Changes_____Signature _____

Date _____Changes_____Signature _____

Date _____Changes_____Signature _____