

PATIENT INFORMATION - CHILD

ALL ABOUT YOUR CHILD

Name: _____
 Last First MI
 Nickname: _____
 Male: _____ Female: _____ Birthdate: ____/____/____ Age: ____
 School: _____ Grade: _____
 Hobbies/Sports: _____
 Child's Home #: () _____
 Child's Home Address: _____
 City: _____ State: _____ Zip: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____
 Parent's Marital Status: _____
 Do you have legal custody of this child?: _____
 Whom may we thank for referring you? _____
 Other family members seen by us: _____

DENTIST

General Dentist: _____
 Date of Last Exam: _____

Mother Step Mother Guardian

Name: _____
 First Last
 Employer: _____
 Work #: () _____ Ext: _____
 Home #: () _____
 Email: _____
 How long at current job?: _____ Title: _____
 Do you have dental insurance with orthodontic coverage?: _____

Father Step Father Guardian

Name: _____
 First Last
 Employer: _____
 Work #: () _____ Ext: _____
 Home #: () _____
 How long at current job?: _____ Title: _____
 Email: _____
 Do you have dental insurance with orthodontic coverage?: _____

Who will be responsible for making appointments?: _____
 Who will be responsible for the account?: _____

What are your main concerns that you would like orthodontics to accomplish?: _____

Has your child ever had or been evaluated for orthodontic treatment? Yes No

Have there ever been any injuries to the face, mouth, teeth or chin? Yes No

Has your child ever been informed of any missing or extra permanent teeth? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

Child's Physician: _____

Phone #: _____

Is your child currently under the care of a physician?: _____

Please list all drugs your child is currently taking: _____

Please list all drugs/things your child is allergic to: _____

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Allergies to any drugs
Y N Allergic to Latex/Metals	Y N Allergic to Plastic
Y N Asthma	Y N Cancer
Y N Congenital Heart Defects	Y N Convulsions/ Epilepsy
Y N Diabetes	Y N Handicaps/Disabilities
Y N Hearing Impairment	Y N Heart Murmur
Y N Hemophilia	Y N Hepatitis
Y N HIV+/ AIDS	Y N Hospitalization
Y N Kidney/Liver Problems	Y N Operations
Y N Rheumatic/ Scarlet Fever	Y N Tuberculosis

Please list any medical problems that your child has had: _____

Does your child ever had any of the following habits?

Y N Clenching/Grinding	Y N Lip Sucking/Biting
Y N Nail Biting	Y N Tongue Thrusting
Y N Mouth Breathing	Y N Thumb/Finger Sucking
Y N Soda Pop Drinker	

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature of parent or guardian _____ Date _____

Reviewed _____ Date _____

Alvetro Orthodontics Lisa Alvetro DDS, MSD, Inc.



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