#

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# **Child New Patient Information Form**

# **Patient Information**

Preferred Name       Sex: [ ]  Male [ ]  Female

First Name       Last Name       Middle Initial

Date of Birth       Grade       School Attends Social Security #

Name/Relationship of Person Accompanying Patient to Today’s Appointment

Patient lives with whom/Relationship

Who has legal custody of patient

Name of Siblings & ages

Whom may we thank for referring you?

# **Responsible Party**  [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed [ ]  Single

Mother’s name       Father’s name

[ ]  Parent [ ]  Guardian [ ]  Stepmother [ ]  Parent [ ]  Guardian [ ]  Stepfather

Date of Birth       SSN       Date of Birth       SSN

Address       Address

City, State, Zip Code       City, State, Zip Code

How long at this address?       How long at this address?

Cell phone (     )     -      Cell phone (     )     -

Work phone (     )       -       Work phone (     )      -

Employer       Years Employed       Employer       Years Employed

Occupation       Occupation

Email Address       Email Address

Who will be responsible for bringing the patient to orthodontic appointments?

# **Emergency Contact** [ ]  Check here if same as above

Emergency contact       Relationship to patient

Cell phone (     )     -      Home phone (     )       -

**Primary Dental Insurance** [ ]  Check here if no orthodontic coverage will be applied

Primary policy holder’s full name       Relationship to patient:

Suscriber ID/Social Security #       Birthdate

Insurance company       Insurance phone #

Employer/Group Name       Group #

Does this policy have orthodontic benefits? [ ]  Yes [ ]  No [ ]  Don’t know

**Secondary Dental Insurance** [ ]  Check here if no secondary insurance

Primary policy holder’s full name       Relationship to patient:

Suscriber ID/Social Security #       Birthdate

Insurance company       Insurance phone #

Employer/Group Name       Group #

Does this policy have orthodontic benefits? [ ]  Yes [ ]  No [ ]  Don’t know

**Please read**: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, bipolar disorder, autism, etc.

# **Medical History**

Physician       Phone       Date of last exam

1. Are you under medical treatment now? [ ]  Yes [ ]  No
2. Have you been hospitalized for any surgical operations or serious [ ]  Yes [ ]  No

Illness in the past five years?

1. Are you taking medication(s) including non-prescription medicine? [ ]  Yes [ ]  No

If yes, what medications are you taking?

1. Do you use tobacco? [ ]  Yes [ ]  No
2. Are you aware of being allergic to any medications or substance, [ ]  Yes [ ]  No

including metals?

If yes, what?

1. Females Only:
	1. Are you pregnant, or think you may be? [ ]  Yes [ ]  No
	2. Are you lactating? [ ]  Yes [ ]  No
2. Have you ever taken bisphosphonates (Ex: Fosamax) for osteoporosis? [ ]  Yes [ ]  No

If yes, specify:

1. Please check all that apply:

Hay Fever/Allergies [ ]  Leukemia [ ]

Cold Sores [ ]  Kidney/Liver Disease [ ]

Migraines/Frequent Headaches [ ]  Anemia [ ]

Diabetes/Low Blood Sugar [ ]  Cancer/Tumor [ ]

Rheumatic Fever [ ]  Joint Replacement/Implant [ ]

AIDS or HIV Infection [ ]  Hepatitis/Jaundice [ ]

Cardiac Pacemaker [ ]  Stomach Troubles/Ulcers [ ]

Asthma (Inhaler) [ ]  Sinus Problems [ ]

Fainting/Seizures [ ]  Stroke [ ]

Endocrine/Thyroid Problem [ ]  Radiation Therapy [ ]

High/Low Blood Pressure [ ]  Respiratory Problems [ ]

Heart Trouble/Defects [ ]  Bone Disorder [ ]

Epilepsy/Convulsions [ ]  Osteopenia/Osteoporosis [ ]

Removal of Adenoids/Tonsils [ ]  Birth defects/Hereditary problems [ ]

Bone Fractures/Major Injuries [ ]  Mental Health Problems/Depression [ ]

Arthritis/Joint Problems [ ]  Glaucoma [ ]

Vision/Hearing/Speech Problems [ ]  Other       [ ]

1. Have you had allergies to the following:

[ ]  Local anesthetics (novacaine, lidocaine, xylocaine) [ ]  Latex (gloves, balloons)

[ ]  Aspirin [ ]  Ibuprofen (Motrin, Advil) [ ]  Penicillin

[ ]  Other antibiotics [ ]  Metals (jewelry, clothing snaps)

[ ]  Other substances

# General Information

1. What concerns you about your smile?
2. Who suggested that you might need orthodontic treatment?
3. Why did you select our office?
4. Have you had any previous orthodontic treatment? Please describe
5. Have any other family members been treated in this office? Please name them
6. Do you think that any of your school or leisure activities affect your teeth or jaws? Please explain

# **Dental History**

Dentist       Phone       Date of last cleaning

1. Are you anxious or nervous about dental treatment? [ ]  Yes [ ]  No
2. Do you require premedication for dental treatment? [ ]  Yes [ ]  No
3. Have you noticed any changes in your face or jaws? [ ]  Yes [ ]  No
4. Do you feel pain to any of your teeth? [ ]  Yes [ ]  No
5. Do you have any sores or lumps in or near your mouth? [ ]  Yes [ ]  No
6. Have you had any head, neck, or jaw injuries? [ ]  Yes [ ]  No

If yes, please describe:

1. Do you have any ongoing problems in your jaw with:
2. Chronic clicking or popping? [ ]  Yes [ ]  No
3. Pain? [ ]  Yes [ ]  No
4. Difficulty opening or closing? [ ]  Yes [ ]  No
5. Difficulty in chewing? [ ]  Yes [ ]  No
6. Do you clench or grind your teeth? [ ]  Yes [ ]  No
7. Do you bite your lips or cheeks frequently? [ ]  Yes [ ]  No
8. Have you ever had speech therapy? [ ]  Yes [ ]  No

If yes, please describe:

1. Is there any outstanding dental treatment to be completed? [ ]  Yes [ ]  No

If yes, please describe:

1. Have you ever had instruction on the correct method of brushing

and flossing of your teeth? [ ]  Yes [ ]  No

1. Do you have or have you had any of the following oral habits:
2. Nail biting [ ]  Yes [ ]  No
3. Thumb sucking [ ]  Yes [ ]  No
4. Tongue thrust while swallowing [ ]  Yes [ ]  No
5. Mouth breathing [ ]  Yes [ ]  No
6. How many times a day do you brush?
7. Please check the boxes below which describe the problem(s) for which you are seeking:

[ ]  Crowding [ ]  Spacing [ ]  Missing Teeth

[ ]  Extra Teeth [ ]  Teeth stick out too far [ ]  TMJ problems

[ ]  Teeth in the wrong position [ ]  Poor bite relationship [ ]  Gummy smile

[ ]  Decreased lip support [ ]  Worn/Misshapen teeth [ ]  Other

1. Have you had an orthodontic evaluation or treatment before? [ ]  Yes [ ]  No

If so, when and by whom?

# **Authorization and Release**

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date 3/21/18

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date 3/21/18

Print Name       Relationship to Patient