THE Art OF BRACES
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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 illness in the past five years? _____ ☐ Yes ☐ No
3. Are you taking medication(s) including non-prescription medicine? ☐ Yes ☐ No
   If yes, what medications are you taking? _____
4. Do you use tobacco? ☐ Yes ☐ No
5. Are you aware of being allergic to any medications or substance, including metals? ☐ Yes ☐ No
   If yes, what? _____
6. Females Only:
   a. Are you pregnant, or think you may be? ☐ Yes ☐ No
   b. Are you lactating? ☐ Yes ☐ No
7. Have you ever taken bisphosphonates (Ex: Fosamax) for osteoporosis? ☐ Yes ☐ No
   If yes, specify: _____
8. 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 _____	☐

9. 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: _____
7. Do you have any ongoing problems in your jaw with:
   a. Chronic clicking or popping? ☐ Yes ☐ No
   b. Pain? ☐ Yes ☐ No
   c. Difficulty opening or closing? ☐ Yes ☐ No
   d. Difficulty in chewing? ☐ Yes ☐ No
8. Do you clench or grind your teeth? ☐ Yes ☐ No
9. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
10. Have you ever had speech therapy? ☐ Yes ☐ No
    If yes, please describe: _____
11. Is there any outstanding dental treatment to be completed? ☐ Yes ☐ No
    If yes, please describe: _____
12. Have you ever had instruction on the correct method of brushing and flossing of your teeth? ☐ Yes ☐ No
13. Do you have or have you had any of the following oral habits:
    a. Nail biting ☐ Yes ☐ No
    b. Thumb sucking ☐ Yes ☐ No
    c. Tongue thrust while swallowing ☐ Yes ☐ No
    d. Mouth breathing ☐ Yes ☐ No
14. How many times a day do you brush? _____
15. 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

16. 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 4/24/18

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 4/24/18

Print Name _____ Relationship to Patient _____