# 

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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