

# 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 immediate 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 # ( \_\_\_\_\_ )  
 Email: \_\_\_\_\_  
 How long at current job? \_\_\_\_\_ Title: \_\_\_\_\_  
 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? \_\_\_\_\_

	Yes	No
Has your child ever had or been evaluated for orthodontic treatment?		
Have there ever been any injuries to the face, mouth, teeth or chin?		
Has your child ever been informed of any missing or extra permanent teeth?		
Does your child brush his/her teeth daily?		
Floss his/her teeth daily?		
Has puberty begun?		
Has menstruation begun? (Girls)		
<b>Has your child ever experienced pain or discomfort in their jaw joint (TMJ/TMD)?</b>		

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: \_\_\_\_\_  
 \_\_\_\_\_

## Has 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 medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of parent or guardian

Date

Reviewed

Date



**MALONE ORTHODONTICS**

jacqueline m. malone, dmd, ms, pc

*Share a Smile...*