Today's Date: _____

Patient's Name: _____ Nickname _____

Patient's Birth Date: _____ Age _____ Gender: _____

Child's physician: _____ Office Phone: _____

Physician's Address: _____ Date of last exam: _____

Is your child in good health …… Yes ____ No ____ Do not know _____

Does your child have a health problem …… Yes ____ No ____ Do not know _____

If yes, explain: _____

Has your child ever been hospitalized, had general anesthesia, or emergency room visits …… Yes _____ No ____ Do not know _____

Are your child's immunizations up to date …… Yes _____ No ____ Do not know _____

Does your child have allergies to medications (drugs), medical products (latex), or the environment (dust, mites, pollen, mold) ……. Yes _____ No ____ Do not know _____

List past medications taken by your child: _____

List daily medications child is now taking: _____

Has your child ever had or been treated by a physician for:

Check one for each condition.

Yes	No	?			Yes	No	?	
			a. Problems at birth					p. Cancer
			b. Heart murmur					q. Cerebral Palsy
			c. Heart disease					r. Seizures
			d. Rheumatic fever					s. Asthma
			e. Anemia					t. Cleft lip/palate
			f. Sickle Cell anemia					u. Speech or hearing problems
			g. Bleeding/hemophilia					v. Eye problems/contact lenses
			h. Blood transfusion					w. Skin problems
			i. Hepatitis					x. Tonsil/adenoid/sinus problems
			j. AIDS or HIV+					y. Sleep problems
			k. Tuberculosis					z. Emotional/behavior problems
			l. Liver disease					aa. Radiation therapy
			m. Kidney disease					bb. Growth problems
			n. Diabetes					cc. Attention deficit disorders
			o. Arthritis					

If yes to any above, please explain this or any other problem: _____

_____

Has your child had any recent rapid growth? _____ If so, how much? _____

Parents: (Father) Ht: _____ Wt: _____ (Mother) Ht: _____ Wt: _____

Older brothers and sisters: (1) Ht: _____ Wt: _____ (2) Ht: _____ Wt: _____ (3) Ht: ____ Wt: _____

Name Child's of School: _____ Child's grade in school: _____

Do you consider your child to be: Advanced learner _____ Progressing normally _____ Slow learner _____

What is your main concern about your child's dental condition? _____

Has your child been to a dentist before? No _____ Yes _____ If yes, date of last visit: _____

Regular dentist's name: _____

Check one for each condition:

Yes	No	?	
			a. Has your child ever had dental x-rays? Date of last x-rays? _____
			b. Will your child be uncooperative? If yes, explain: _____
			c. Has your child experienced any complications following dental treatment? If yes, explain: _____
			d. Has your child had cavities and/or toothaches?
			e. Are your child's teeth sensitive to temperature or food?
			f. Did you or your child ever get instructions in brushing?

			g. Do your child's gums bleed when brushed?
			h. Does your child use fluoride products: rinses, drops, tabs?
			i. Does or has your child had any clicking or pain in the jaw joint?
			j. Does or has your child had any problems opening or closing their mouth?
			k. Has your child inherited any family facial or dental characteristics? If yes, explain: _____
			l. Has your child ever injured his/her teeth?
			m. Has your child ever injured his/her jaws or face?
			n. Does or did your child use a pacifier?
			o. Does or did your child suck his/her fingers or thumb?

Responsible Party Information

(1) Name: _____ Maiden Name (if Applicable) _____
Gender _____ Birth Date _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-mail Address _____
Residence Address _____
City _____State _____ Zip _____
Mailing Address (if different) _____
City _____State _____ Zip _____
(2) Name: _____ Maiden Name (if Applicable) _____
Gender _____ Birth Date _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-mail Address _____
Residence Address _____
City _____State _____ Zip _____
Mailing Address (if different) _____
City _____State _____ Zip _____

Insurance Information

Insured's Name _____ DOB _____
Insured's Member ID # OR Soc. Sec. # _____ Group # _____
Insurance Company _____ Insured's Employer _____
Insurance Co. Address _____ Ins Co Phone # _____
Do you have Dual Coverage? Yes _____ No _____ ***If YES***, please continue:
Insured's Name _____ DOB _____
Insured's Member ID # OR Soc. Sec. # _____ Group # _____
Insurance Company _____ Insured's Employer _____
Insurance Co. Address _____ Ins Co Phone # _____

Emergency Contact Information

Name of nearest relative Not living with you _____
Complete Address _____
Phone Number _____ Relationship to Patient _____

Does your child have any other dental problems we should know about? _____ Please explain: _____
_____
Whom may we thank for referring you to our office? _____
Person completing this form: Signature _____
Relationship to patient: _____

Click SUBMIT button to send your completed form to our office. This button only works in Acrobat.
If you are having trouble, you can send the form in an email to: fc1@byrneorthodontics.com

SUBMIT