Guilford, Hamden & East Haven/Branford Locations

(203) 288 – 0900

www.dr-orthodontics.com

PATIENT INFORMATION *for* CHILD

Date:____________________

Childs's Name:____ Nickname:_________________ Gender:_______

Date of Birth:_____________________ Age:_____ School:__________________________________ Grade:_______

Child's Hobbies: ____

Has anyone in your family been treated in our office?____

Please list all sibling(s) & age(s):____

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Parent / Guardian

Name: _____________________________________

Marital Status:______________________________

Address: ___________________________________

____

Cell #:_____________________________________

Home #:___________________________________

Email:______________________________________

Date of Birth:_______________________________

Social Security #:____________________________

Occupation/Employer: ______________________

Parent / Guardian

Name: _____________________________________

Marital Status:______________________________

Address: ___________________________________

____

Cell #:_____________________________________

Home #:___________________________________

Email:______________________________________

Date of Birth:_______________________________

Social Security #:____________________________

Occupation/Employer: ______________________

Responsible Party Name: ____

How did you hear about our office? Dentist Website Facebook Instagram Friend: _________________

Are you on Facebook? Yes No Please join us @ www.facebook.com/DRorthodontics

Are you on Instagram? Yes No Please join us @ DRorthodontics

GROWTH ASSESSMENT

Has the patient grown in the last year? Yes No How much: ___________

Child's height:___________ Mother's height:___________ Father's height:___________

Has the patient's shoe sized changed recently? Yes No How much:___________

Has the patient reached puberty? Yes No

TURN OVER

MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality	Diabetes	Cancer/Tumor	Hearing Impairment
Rheumatic/Scarlet fever	HIV/AIDS	GI Disorder	Speech Disorder
Artificial Heart Valve	Hepatitis	Epilepsy/Seizures	Fainting/Dizziness
High/Low Blood Pressure	Bronchitis	Autism	Nervous/Anxious
Kidney/Liver problems	Asthma	Cleft Lip/Palate	Tactile Defensive
Bleeding Abnormality	Thyroid Disorder	Birth Defect(s)	Major Surgery
Sickle Cell Anemia	Bone Disorder	Growth Disorder	Currently Pregnant
Tuberculosis	Artificial Joints	Tonsils/Adenoids removed	**NONE**

If circled, please explain: ____________________

Condition not listed: ____________________

Any allergies? Yes No Please explain: ____________________

Any medications? Yes No Please explain: ____________________

DENTAL HISTORY

Child's Dentist:	Last Dental Visit:
Any previous orthodontic consults? Yes No	If so when:
Any previous orthodontic treatment? Yes No	Please explain:
Main orthodontic concern:	

Prior facial/dental injuries: ____________________

Oral habits (e.g. sucking thumb): ____________________ Until age: ________

TMJ problems (clicking or pain): ____________________

Excessive grinding/clenching: ____________________ Mouth breathing: ____________________

Tongue Thrusting: ____________________ Missing or extra permanent teeth: ____________________

Any family history of jaw/orthognathic surgery: ____________________

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

Parent / Guardian Signature: ____________________ **Date:** ____________

OFFICE USE ONLY

Right: Class I Class II______ Class III______ X-B______

Left: Class I Class II______ Class III______ X-B______

OJ: ________ **OB**: Ideal Deep ________ Open ________

Upper: Crowding ____________ Spacing ____________

Lower: Crowding ____________ Spacing ____________

Other: ____________________

____

Oral Hygiene: ________ **Recall:** ____________

Tx Plan: ____________________

____

____

____

Est. Fee: ____________ **Est. Time:** ____________