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Thank you for giving us the privilege of seeing your child. We are anxious to provide the best possible care. Answers to these questions will help make this possible. Thank you, again.

Patient's Name ______________________ Nickname, if any ______________________

Birthdate ____________ Age ________ Sex ☐ Male ☐ Female Child's Interests ______________

Home Phone ______________________ School ______________ Grade __________

Address ______________________ City, State, Zip ______________________

Physician or Pediatrician ______________________ Family Dentist ______________________

Whom can we thank for referring you to this office? ______________________

Names and ages of brothers and sisters ______________________

PARENTS/GUARDIAN INFORMATION

Father/Guardian Name ☐ Mr. ☐ Dr. ______________________ DOB __________

Address ______________________ Zip __________

Home Phone ______________________ Driver's License No. ______________ SSN __________

Employer ______________________ Address ______________ Phone __________

Mother's Name ☐ Mrs. ☐ Ms. ☐ Dr. ______________________ DOB __________

Address ______________________ Zip __________

Home Phone ______________________ Driver's License No. ______________ SSN __________

Employer ______________________ Address ______________ Phone __________

Do Mother, Father, and Child All Live Together? ☐ Yes ☐ No Explain ______________________

Nearest Living Relative Other than Parents/Guardian ______________________ Phone __________

Relation ______________________ Address ______________ Work Phone __________

Person Responsible for Account ______________________ Email ______________________

Name of Insurance ______________________

Mailing Address for Insurance Company ______________________

MEDICAL INFORMATION (please respond to every question)

A. ☐ Yes ☐ No Has your child ever been hospitalized? Emergency Room? ☐ Yes ☐ No Explain __________

B. ☐ Yes ☐ No Is your child now under the care of a physician? If yes, why? __________

C. ☐ Yes ☐ No Is your child taking any medications? If yes, what? __________

D. ☐ Yes ☐ No Is your child allergic to anything? If yes, what? __________

E. ☐ Yes ☐ No Has your child ever had a reaction to penicillin or any other drug? If yes, what drug(s)? __________

F. Does your child now have or ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐	Birth Defects
☐	☐	Heart Disease	☐	☐	Blood Transfusion	☐	☐	Cancer
☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease or Trait	☐	☐	AIDS
☐	☐	Liver Disease	☐	☐	Blood Disorders	☐	☐	Eye Problems
☐	☐	Kidney/Bladder Disease	☐	☐	Mental Retardation	☐	☐	Hearing Problems
☐	☐	Respiratory Disease	☐	☐	Cerebral Palsy	☐	☐	Cleft Lip/Palate
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Speech Problems
☐	☐	Tuberculosis	☐	☐	Diabetes	☐	☐	__________ OTHER
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	__________

Please continue on other side

DENTAL HISTORY / Purpose of this call ____________________

☐ Yes ☐ No Is this your child's first visit to an orthodontist? If no, date of last visit? ____________

What was done for your child on the previous visit? ____________

☐ Yes ☐ No Has your child's teeth ever been x-rayed? When and by whom? ____________

☐ Yes ☐ No Has your child ever sucked his/her fingers?

☐ Yes ☐ No Thumb? ☐ Yes ☐ No Pacifier? ☐ Yes ☐ No Habit still active?

☐ Yes ☐ No Does your drinking water contain fluoride?

☐ Yes ☐ No Has your child ever had injury to face or teeth? If yes, when? ________ Describe ____________

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all costs incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and venue to be held in Davidson County. Signature on file for submission of insurance claims.

Patient ____________________ Date ____________

Reviewed by ____________________ Date ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• You may refuse to sign this acknowledgement •

I, ____________________ have received a copy of this office's Notice of Privacy Practices.

____
PLEASE PRINT NAME

____
SIGNATURE

____
DATE