CURTIS & BARYSENKA
Sycamore
ORTHODONTICS

1) TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____

Nickname: _____ ☐ MALE ☐FEMALE

Child's Date of Birth: _____ Age: _____

School: _____Grade: _____

Child's Home # (__)_____

Child's Home Address: _____

_____

Sports, Hobbies, Interests: _____

_____

2) Referral Information

How did you hear about our office?

_____

List Siblings with Ages: _____

_____

Have any family members been patients at our office?

_____

General Dentist: _____

Date of Last Visit: _____

Parents of Child Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do you have legal custody of this child? ☐Y☐N

3) Parent's Information

Mother's Name:_____DOB:__/__/__

SS#_____Cell #_____

Work# _____

Father's Name:_____DOB:__/__/__

SS#_____Cell#_____

Work # _____

4) PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship:_____

Billing Address: _____

_____

Home# (___)_____Work# (___)_____

Employer: _____

Who is responsible for making appointments?

_____

Name: _____

Text reminders? ☐Y☐ N Email: _____

5) Orthodontic Insurance

Primary: Orthodontic Coverage? ☐Y☐N

Insurance Company: _____

Insurance Company Phone# (__)_____

Subscribers #_____

Group #_____

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's DOB: __/__/__SS#_____

Policy Holder's Employer: _____

Relationship to Patient: _____

Secondary: Orthodontic Coverage? ☐ Y ☐ N

Insurance Company: _____

Subscribers #_____

Policy Holder's Name: _____

Policy Holder's DOB: __/__/__SS#_____

Policy Holder's Employer: _____

6) Tell US YOUR CONCERNS

What are your main concerns that you would like Orthodontics to accomplish: _____

_____

_____

Have you been to our office before? ☐Y☐N

Has your child ever had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐Y☐N

Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N

Has your child ever had any pain/tenderness in his/her jaw joint(TMJ/TMD)? ☐Y☐N

Does your child brush teeth daily? ☐Y ☐N

Floss teeth daily? ☐Y☐N

Is your child currently under the care of a physician? ☐Y ☐N

Child's Physician: _____

Phone #(___)_____

Date of last visit: _____

Please describe your child's current physical health:

☐Good ☐Fair ☐Poor

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs your child is allergic to: _____

_____

7) Has Your Child Ever Had Any of the Following:

Abnormal Bleeding ☐Y☐N

Allergies to any drugs ☐Y☐N

Allergy to latex/metals ☐Y☐N

Allergic to plastics ☐Y☐N

Any hospital stays ☐Y☐N

Any operations ☐Y☐N

Asthma ☐Y☐N

Cancer ☐Y☐N

Congenital Heart Defect ☐Y ☐N

Rheumatic/Scarlet Fever ☐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

Kidney/Liver Problems ☐Y☐N

Tuberculosis ☐Y ☐N

Epilepsy ☐Y☐N

Please explain any medical problems that your child has had:

_____

_____

_____

8) Does/Did Your Child Have Any of the Following Habits?

Clenching/Grinding Teeth ☐Y ☐N

Lip Sucking/Biting ☐Y ☐N

Mouth Breather ☐Y ☐N

Poor Oral Hygiene ☐Y ☐N

Nail Biting ☐Y ☐N

Baby Bottle Habits ☐Y☐N

Speech Problems ☐Y ☐N

Thumb/Finger Sucking ☐Y ☐N

Tongue Habit ☐Y ☐N

Relative or Friend not living with you:

Name: _____

Phone: (__)_____

Address: _____

Will anyone besides a parent/guardian be accompanying the patient to appointments? ☐Y ☐N

Name: _____

Relation: _____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date

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