n a t h a n THOMAS orthodontics

Patient Information – Child

Patient's Name:____

Nickname: ____________________ Birthdate: __________________ Male: _____ Female: ______Age:_________________

School: ________________________ Sports/Hobbies: ____

Child's Home #:_______________________________SS#:____

Child's Home Address: ____

Ethnicity: ___ Caucasian ___ African American ___ American Indian ___ Asian ___Hispanic ___ Other: ___________

Whom may we thank for referring you?: ____

Primary Responsibility

SS#:__________________________ Birthdate: ____________________

___Mother ___ Father ___ Step Mother ___ Step Father ___Guardian

Name: ____

Address: ____

Home phone: ______________________ Work phone: ____

Cell/other phone: ______________________ Email address:____

Employer: _________________________________ Occupation: __________________ No. years employed: _____________

Secondary Responsibility

SS#:__________________________ Birthdate: ____________________

___Mother ___ Father ___ Step Mother ___ Step Father ___Guardian

Name: ____

Address: ____

Home phone: ______________________ Work phone: ____

Cell/other phone:______________________ Email address: ____

Employer: _________________________________ Occupation: __________________ No. years employed: _____________

Who is Accompanying Your Child Today?

Name: ________________________________ Relation: _____________________

Parent's Marital Status: ____________________________ Other family members seen by us: __________________________

What are your main concerns that you would like orthodontics to accomplish?:

____

Has your child ever been evaluated for orthodontic treatment? Yes___ No___

(Continued on back)

Dental History

General Dentist:______________________________ Date of Last Exam: ______________________

Do you have any dental concerns at this time?____

Yes No Have there ever been any injuries to the face, mouth, teeth or chin?
-If yes, please explain: ____
Yes No Has your child ever been informed of any missing or extra teeth?
-if yes, please explain: ____
Yes No Does your child brush his/her teeth daily?
Yes No Floss his/her teeth daily?
Yes No Has puberty begun?
Yes No Has menstruation begun? (Girls)
Yes No Does your child now have or ever experienced pain or discomfort in their jaw joint (TMJ/TMD)?

Does your child have any of the following habits?
Yes No Clenching/Grinding
Yes No Mouth Breathing
Yes No Nail Biting
Yes No Soda Pop Drinker
Yes No Lip Sucking/Biting
Yes No Tongue Thrusting
Yes No Thumb/Finger Sucking

Medical History

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: ____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Congenital Heart Defect	Heart Murmur	Nervous Disorders
Allergy to Latex/Metals	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
			Tumor or Cancer

Please list any medical problems that your child has had: ____________________________________

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Acknowledgement

The information provided is correct to the best of my knowledge. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Nathan Thomas to perform a complete orthodontic evaluation.

Signature: ____ Date: ____________________