Welcome to our office.
So that we might become better acquainted, please complete both pages of this form.

## CHILD PATIENT INFORMATION

Patient's Name____________________________________Preferred Name________________Sex___

Home Address____________________________________City___________________Zip__________

Patient resides with: Mother___Father___Both___Other_____________________________________

Home Phone_________________Age____Birthdate__________School________________Grade____

Patient interests:______________________________________________________________________

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Please describe your child's orthodontic problem in your own words:___________________________

Who may we thank for referring you to our office? __________________________________________

Parent's Marital Status: Married___ Separated___ Divorced___ Widowed___ Single___

| | FATHER | MOTHER |
|---|---|---|
| Name | ______________________________ | ______________________________ |
| Address<br>(If different than above) | ______________________________ | ______________________________ |
| City, State, Zip | ______________________________ | ______________________________ |
| Cell Phone # | ______________________________ | ______________________________ |
| Email Address | ______________________________ | ______________________________ |
| Social Sec. # | ______________________________ | ______________________________ |
| Occupation | ______________________________ | ______________________________ |
| Employer | ______________________________ | ______________________________ |
| Business Phone | ______________________________ | ______________________________ |

Person responsible for account__________________________________________________________
*If other than parent:*

Name________________________Address____________________________Phone______________

### OrthoBanc Credit Authorization

I hereby authorize OrthoBanc, LLC, on behalf of Dr. Brett Fidler to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. **NOTE:** Obtaining an OrthoBanc credit recommendation does not alter the responsible party's credit score in any way.

Signature_________________________________________________________Date________________
Person responsible for payment

**Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.**

## MEDICAL HISTORY

Physician's Name______________________Address___________________________________Phone________________

Has your child experienced any health problems? No__Yes__Explain__________________________________________

Any major change in your child's health recently? No__Yes__Explain__________________________________________

Is your child currently under a physician's care? No__Yes__Explain__________________________________________

Is your child currently taking any medications? No__Yes__List_____________________________________________

Is your child allergic to any medications? No__Yes__List_____________________________________________

Has your child received a blood transfusion? No__Yes__Reason__________________________________________

Have your child's tonsils or adenoids been removed?No__Yes__When_________________________________________

Has your child been in a risk group for AIDS? No__Yes__Explain__________________________________________

Please check if your child has had any of the following conditions:

Heart Murmur…………..No__Yes__ Hepatitis…………No__Yes__ Emotional Problems…….No__Yes__

Heart Surgery…………...No__Yes__ Diabetes…………No__Yes__ Frequent Headaches….…No__Yes__

Rheumatic Fever………..No__Yes__ Kidney Disease….No__Yes__ Nervous/Anxious………..No__Yes__

Endocrine Disorders…….No__Yes__ Liver Disease……No__Yes__ Cancer…………………...No__Yes__

Prolonged Bleeding……..No__Yes__ Tuberculosis……. No__Yes__ Bone Disorders…………..No__Yes__

Anemia…………………No__Yes__ Bronchitis………..No__Yes__ Growth Disorders………..No__Yes__

Blood Disease…………..No__Yes__ Asthma…………..No__Yes__ Mouth Breather……….....No__Yes__

Developmental Disorder..No__Yes__ Epilepsy………….No__Yes__ Herpes (fever blisters)…...No__Yes__

Hives/Rash……………...No__Yes__ Fainting..…………No__Yes__ Tonsilitis……………...…No__Yes__

Is there any other condition or problem that you think we should know about?__________________________________

_____________________________________________________________________________________________

Comments_____________________________________________________________________________________

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty?……… No__Yes__

Girls – Has she started menstruation?……. No__Yes__When?_________________________________________

Boys – Has his voice changed?………….. No__Yes__When?_________________________________________

Height_________Do you feel growth is completed? No__Yes__

Father's Height_____Mother's Height______Adopted No__Yes__

Names and birthdates of patient's brothers and sisters______________________________________________________

Have either siblings or parents had orthodontic treatment? No__Yes__With whom?____________________________

## DENTAL HISTORY

Dentist's Name____________________Address___________________________Phone_________________________

Frequency of dental checks:

Twice a year__ Once a year__ Only if a problem exists__ Never__ Date of last visit__________________________

Is there any unfinished care to be completed with your child's dentist? No__Yes__Explain________________________

Is your child frightened about dental treatment? No__Yes__Explain________________________________

Has your child had an unpleasant experience in a dental office? No__Yes__Explain_______________________

Has your child had any face or dental injuries? No__Yes__Explain________________________________

Is there any history of thumb or finger sucking? No__Yes__Stopped?______________________________

Does your child play a musical instrument? No__Yes__Which?_____________________________________

Has your child consulted an orthodontist previously? No__Yes__With whom?___________________________________

Have teeth (either primary or permanent) been removed? No__Yes__

Has your child had any previous orthodontic treatment? No__Yes__With whom?__________________________

Are you satisfied with prior treatment? No__Yes__Explain________________________________

**Please check if there is a history of:**

Clenching teeth__ Muscular soreness around head and neck__ Jaw joint soreness__ Jaw joint popping__

Grinding teeth__ Headaches (more than normal)__ Jaw joint clicking__ Ringing in the ears__

Speech problems No__ Yes__ If so, which sounds?____________________________________________________

Is there any other information that may be helpful?__________________________________________________________

Parent's Signature___________________________Date________Reviewed by___________________________