

# WELCOME

## Patient Information

Name of Child \_\_\_\_\_ Nickname \_\_\_\_\_  
Sex: M \_\_\_ F \_\_\_ Age \_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Musical Instrument Played \_\_\_\_\_  
Sports And /Or Hobbies \_\_\_\_\_  
Names and ages of brothers and sisters \_\_\_\_\_  
Whom may we thank for referring you \_\_\_\_\_

## Parent's/Guardian's Information

Father's/Guardian's Name _____	Mother's/Guardian Name _____
Address (if different) _____	Address (if different) _____
Home Phone _____	Home Phone _____
Cell/Work # _____	Cell/Work # _____
Social Security # _____	Social Security # _____
Birth date _____	Birth date _____
Employer _____	Employer _____
Address _____	Address _____
Do you have dental insurance coverage? _____	Do you have dental insurance coverage? _____
Plan Name _____	Plan Name _____
Phone Number _____	Phone Number _____
Group # _____ Policy # _____	Group # _____ Policy # _____

## Dental History

Name of Dentist \_\_\_\_\_  
Date of last visit to your dentist \_\_\_\_\_ for what service \_\_\_\_\_  
Does child brush teeth daily \_\_\_ Yes \_\_\_ No      Does your child floss daily \_\_\_ Yes \_\_\_ No  
Is fluoride taken in any form \_\_\_ Yes \_\_\_ No      Periodontal Treatment \_\_\_ Yes \_\_\_ No  
Clicking or popping of the jaw \_\_\_ Yes \_\_\_ No      Grinding \_\_\_ Yes \_\_\_ No  
Injuries to mouth, teeth or head \_\_\_ Yes \_\_\_ No      Does your child follow directions well \_\_\_\_\_  
Does your child currently chew or smoke tobacco \_\_\_ Yes \_\_\_ No  
Orthodontic appliances worn now or ever \_\_\_ Yes \_\_\_ No  
Any family member had/has orthodontia \_\_\_ Yes \_\_\_ No      Relationship \_\_\_\_\_  
Any unhappy dental experiences? \_\_\_\_\_  
Does patient have any learning disabilities or need extra help with instructions? \_\_\_\_\_  
Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.?  
\_\_\_\_\_

Please complete both sides

## Medical History

Child's Physician \_\_\_\_\_ City/ State \_\_\_\_\_  
Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_  
Is child under care of physician now? \_\_\_Yes \_\_\_No Ever been hospitalized? \_\_\_Yes \_\_\_No  
Ever had surgery? \_\_\_Yes \_\_\_No Is there excessive bleeding when cut? \_\_\_Yes \_\_\_No  
Are there any other medical conditions we should be aware of? \_\_\_\_\_ If so please explain \_\_\_\_\_

Has your child had any history with any of the following? If yes, please mark with an x.

___Anemia	___Diabetes	___HIV/AIDS	___Sinus Problems
___Asthma	___Drug/Alcohol Abuse	___Kidney Disease	___Thyroid Disease
___Bladder Problems	___Epilepsy	___Liver Disease	___Tuberculosis
___Cancer	___Fainting	___Measles	___Other
___Cerebral Palsy	___Hearing Problems	___Mononucleosis	
___Chicken Pox	___Heart Problems	___Mumps	
___Convulsions	___Hepatitis	___Rheumatic Fever	

Allergies or reactions to any of the following: If yes, please mark with an x.

___Local anesthetics (Novocaine or Lidocaine)	___Aspirin
___Ibuprofen (Motrin or Advil)	___Penicillin or other antibiotics
___Sulfa drugs	___Codeine or other narcotics
___Metals (jewelry, clothing snaps)	___Latex (gloves, balloons)
___Vinyl	___Acrylic
___Animals	

Foods \_\_\_\_\_ Other Substances \_\_\_\_\_

Is the patient taking medication, nutrient supplements, herbal or non-prescription medicine? Please name them.

Medication _____	Taken for _____
Medication _____	Taken for _____
Medication _____	Taken for _____

### GIRLS ONLY

Has the patient started her monthly periods? \_\_\_\_\_ If so approximately when? \_\_\_\_\_  
Is the patient pregnant? \_\_\_\_\_

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I hereby request that Dr. Charles M. Krowicki submit insurance forms on behalf of the above patient, and indicate on those forms that payment is to be made to the insured.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Parent or Guardian

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Dental staff member