MIDDLETON
ORTHODONTICS

CHILD PATIENT INFORMATION - FEMALE

Patient's Name (First, Middle, Last) _____Age_____Birthdate_____

Nickname (if preferred) _____ Patient's Home Phone _____

Patient's Home Address_____ City, State, Zip_____

School name _____ Grade _____

How did you hear about our office? _____

Has your child visited an orthodontist before or had any previous treatment? O Yes O No If Yes, please explain? _____

_____

Have we treated another member of your family? O Yes O No If Yes, Name (First, Last) _____

Siblings (Name, Age) _____

PARENTS/GUARDIAN INFORMATION

Patient Lives With: O Father O Mother O Step-Father O Step-mother O Grandfather O Grandmother O Aunt O Uncle O Guardian O Other

Name (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____

Home # _____ Cell #_____ Email _____

Driver's Lic # _____ Social Security # _____

Employer _____ Work # _____

Name (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____

Home # _____ Cell #_____ Email _____

Driver's Lic # _____ Social Security # _____

Employer _____ Work # _____

If you have DENTAL insurance coverage for the child, please fill out.

Insured Name (First, Last) _____

Relationship to Patient _____Social Security Number _____ Date of Birth _____

Employer _____ Employer Address _____

Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____ Phone Number _____

EMERGENCY INFORMATION

Name of nearest relative not living with you (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____ Phone # _____

DENTAL HISTORY

Patient's General Dentist Name _____ Date of last cleaning_____

Dentist address _____ Phone number _____

Does the child require pre-medication antibiotics before dental treatment? O Yes O No If Yes, explain _____

Have the adenoids or tonsils been removed? O Yes O No Have you been informed of any missing or extra permanent teeth? O Yes O No

Any injuries to the child's face, mouth or chin? O Yes O No Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? O Yes O No

Does the child play a musical instrument? O Yes O No If Yes, what kind? _____

Does/Did the child have any of the following?

O Unfavorable Dental experience	O Clenching or Grinding	O Finger/Thumb Sucking
O Prolonged Bottle/Pacifier	O Mouth Breathing	O Speech Problems
O Chewing/Eating Problems	O Tongue Thrust	O Teeth sensitivity

MEDICAL HISTORY

Is the child currently under the care of a physician? O Yes O No If Yes, for what reason? _____

Child's Physician _____ Phone number _____

History of major illness or medical condition? O Yes O No If Yes, please describe_____

Currently taking any medication? O Yes O No If Yes, please list & Explain:_____

Is the child allergic to LATEX? O Yes O No Any other allergies? O Yes O No If Yes, please list: _____

Did Menstruation start? O Yes O No If Yes, at what age? _____ Are you currently pregnant? O Yes O No If Yes, how many months? _____

Has the child been treated for any of the following?

		O ADHD/ADD	O Autism
O Arthritis	O Asthma	O Blood Disorder	O Cancer
O Diabetes	O Epilepsy/Seizures	O Heart Condition	O HIV/AIDS
O Liver problems/Hepatitis	O Mitral Valve Prolapse	O Nervous Disorder	O Tuberculosis

Please describe any current medical treatment including any medications not mentioned above: _____

Race (optional) O African American O American Indian O Asian O Caucasian O Chinese O Japanese O Korean O Latin O South Pacific

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

SIGNATURE

Relationship _____ Date _____