

# Child Information Form

WELCOME

To assist us in providing the most complete service, please provide the following information and health history.



by Dr. Doleac & Team

Date \_\_\_\_\_

## PERSONAL INFORMATION

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
FIRST MIDDLE LAST

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dentist \_\_\_\_\_

Physician \_\_\_\_\_

### MOTHER

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Employed by \_\_\_\_\_

Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_

SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Marital Status \_\_\_\_\_

Email address \_\_\_\_\_

### FATHER

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Employed by \_\_\_\_\_

Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_

SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Marital Status \_\_\_\_\_

Email address \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

### PRIMARY DENTAL INSURANCE ONLY

Ortho coverage?  Yes  No If "Yes" complete below

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ID# \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

### SECONDARY DENTAL INSURANCE ONLY

Ortho coverage?  Yes  No If "Yes" complete below

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ID# \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

PLEASE COMPLETE OTHER SIDE

## MEDICAL HISTORY

Please check box if patient has or has had:

- |  |   |
|--|---|
| <input type="checkbox"/> Positive HIV test           | <input type="checkbox"/> Tuberculosis                                   |
| <input type="checkbox"/> Joint swelling              | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Bone disorders              | <input type="checkbox"/> Asthma   |
| <input type="checkbox"/> Heart trouble               | <input type="checkbox"/> Epilepsy                                       |
| <input type="checkbox"/> Rheumatic fever             | <input type="checkbox"/> Prolonged bleeding                             |
| <input type="checkbox"/> Thyroid problems            | <input type="checkbox"/> Faintness/dizziness                            |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Tonsils removed                                |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Adenoids removed                               |
| <input type="checkbox"/> Emotional problems          | <input type="checkbox"/> Sore throats                                   |
| <input type="checkbox"/> Brain injury                | <input type="checkbox"/> Tonsillitis                                    |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> Earaches                                       |
| <input type="checkbox"/> Autism Spectrum Disorder    | <input type="checkbox"/> Attention Deficit Hypertension Disorder "ADHD" |

List any other serious illnesses: \_\_\_\_\_

List any allergies: \_\_\_\_\_

List drugs or medications now being taken: \_\_\_\_\_

Is patient under physician's care presently? \_\_\_\_\_

Reason: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Approximately how much has patient grown in the last year? \_\_\_\_\_

Additional comments: \_\_\_\_\_

### How did you find our practice?

- Referred by my dentist, Dr. \_\_\_\_\_
- Referred by a friend/relative \_\_\_\_\_
- Yellow Pages
- Internet
- I am a former patient

## DENTAL HISTORY

Please check box if answer is yes:

- Any injuries to **face, mouth, teeth?** (CIRCLE)
- Thumb, finger, lip sucking?** (CIRCLE)
- Mouth-breathing when **asleep, awake?** (CIRCLE)
- More than average amount of decay?
- Any missing permanent teeth?
- Any teeth removed by extraction?
- Is there any tongue-thrusting problem?
- Any speech problems?
- Any difficulty in swallowing or chewing?
- Any pain or clicking on opening mouth?
- Is patient adopted? At what age? \_\_\_\_\_
- Does patient visit dentist regularly?  
Date of last dental visit \_\_\_\_\_
- Has an orthodontist been consulted previously?  
Reason: \_\_\_\_\_

List any wind instrument played: \_\_\_\_\_

Sports: \_\_\_\_\_

Please describe your reasons for considering orthodontic treatment:

- Improved facial appearance       Improved functional health
- Enhanced long-term dental health
- Other \_\_\_\_\_

Please describe your child's attitude toward orthodontic treatment:

- Wants It Done     Does Not Want It Done     Does Not Care

Please note any other factors the doctor should know about the patient's dental health: \_\_\_\_\_

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.) \_\_\_\_\_

## PATIENT AUTHORIZATION – PLEASE SIGN BELOW

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

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN      DATE

I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN      DATE

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.