WELCOME
To Dr. Taylor Orthodontics

CHILD'S INFORMATION

Male ☐ Female ☐ Today's Date_____

Child's Name _____ Birthdate _____ Age ____
First Last

Address _____
Street City Zip

School _____ Grade _____ Hobbies _____

Names and ages of siblings _____

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

PARENT'S INFORMATION

Marital Status _____

Mother's Name _____ Birth date _____

Occupation _____ Employer _____

Phone_____ Email _____

Father's Name _____ Birth date _____

Occupation _____ Employer _____

Phone_____ Email_____

Person(s) Responsible for Account _____

DENTAL INSURANCE INFORMATION

Name of Insured (Who has the insurance)? _____

Birth date_____ Social Security Number_____

Insurance Company Name _____

Insurance Company Phone _____ ID Number _____

Please provide us with a copy of your dental insurance card. If you have coverage with more than one insurance company, please copy both insurance cards. Thank you!

MEDICAL AND DENTAL HISTORY

Child's Dentist _____ City _____ Phone _____
Child's Physician _____ City _____ Phone _____

Has your child had any major illness, surgery, medical problems? ☐ Yes ☐ No
List (if applicable) _____

List any medications child is currently taking _____

List any medications your child is allergic to _____

List any other allergies (latex gloves, metals, etc.) _____

Is your child currently in good health? ☐ Yes ☐ No

Does your child require antibiotics prior to having routine dental treatment? ☐ Yes ☐ No

Has your child ever had any of the following medical problems?

☐ Y	☐ N	Abnormal Bleeding	☐ Y	☐ N	HIV+ / AIDS
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Kidney / Liver Problems
☐ Y	☐ N	Blood Transfusion	☐ Y	☐ N	Tuberculosis (TB)
☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Asthma
☐ Y	☐ N	Rheumatic / Scarlet Fever	☐ Y	☐ N	Bone Disorders
☐ Y	☐ N	Heart Defect / Murmur	☐ Y	☐ N	Nervous Disorders
☐ Y	☐ N	Cancer	☐ Y	☐ N	Epilepsy / Convulsions

Have there been any injuries to your child's face, mouth, teeth, or chin? ☐ Yes ☐ No
Are you aware of any missing permanent teeth? ☐ Yes ☐ No
Has your child had any jaw joint (TMJ) symptoms or problems? ☐ Yes ☐ No
Has puberty begun? ☐ Yes ☐ No
Has any previous orthodontic treatment been done for your child? ☐ Yes ☐ No

Does your child have any of the following habits?

☐ Y	☐ N	Thumb / Finger Sucking	☐ Y	☐ N	Grinding / Clenching Teeth
☐ Y	☐ N	Tongue Thrusting	☐ Y	☐ N	Mouth Breather
☐ Y	☐ N	Speech Problems	☐ Y	☐ N	Lip Sucking / Biting

Is there a specific problem or reason for your visit today? _____
_____
_____

_____
Parent's Signature