

HODGES AND CAPPS ORTHODONTICS

CHILD PATIENT INFORMATION

Name: _____ Prefer to be called: _____ Sex: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Patient resides with: Mother Father Both Other: _____

Home Phone: _____ Age: _____ Birth date: _____ Social Security#: _____ - _____ - _____

E-mail: _____

Patient's Dentist: _____ School: _____ Grade: _____

Describe your child's orthodontic problem: _____

Patient's interests: _____

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

Parents and Account Information

Parent's Marital Status: Married Separated Divorced Widowed

FATHER

MOTHER

Name: _____

Address (if different than above) _____

Phone (if different than above) _____

Social Security Number: _____

Employer's Name: _____

Business Address: _____

Business Phone: _____

Occupation: _____

How long with this employer: _____

Person responsible for account: _____

If other than parent:

Name: _____ Address: _____ Phone: _____

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee): _____

Date of Birth: _____ Social Security# _____ - _____ - _____

Name of insurance company: _____ Group #: _____

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

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 Explain: _____
Is your child allergic to any medications? No Yes Explain: _____
Has your child received a blood transfusion? No Yes Explain: _____
Have your child's tonsils or adenoids been removed? No Yes Explain: _____

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

- | | | |
|---|---|---|
| Heart Murmur..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Emotional Problems.... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Surgery..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Headaches.... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic Fever..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease... <input type="checkbox"/> No <input type="checkbox"/> Yes | Nervous/Anxious..... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endocrine disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer..... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Prolonged Bleeding..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone Disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anemia..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Bronchitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Growth Disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blood Disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Mouth Breather..... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Developmental Disorder. <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes (Fever Blisters). <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hives/Rash..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Tonsillitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes |

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

Growth Information for Patients Under 16 Years of Age:

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in 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? _____
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? _____

Dentist's Name: _____ Address: _____ Phone: _____

- Dental checkups: 2 times a year 1 time a year Only if 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 the dental office? No Yes Explain: _____
Has your child had any facial or dental injuries? No Yes Explain: _____
Is there any history of thumb or finger sucking? No Yes Explain: _____
Does your child play any musical instruments? No Yes Explain: _____
Has your child consulted an orthodontist previously? No Yes Explain: _____
Have teeth (either primary or permanent) been removed? No Yes Explain: _____
Has your child had any previous orthodontic treatment? No Yes Explain: _____
Are you satisfied with prior treatment? No Yes Explain: _____
Any changes in your child's bite or dental alignment recently? No Yes Explain: _____

Please check if there is a history of:

- Clenching teeth Muscular Soreness around head & neck Jaw joint soreness Jaw joint popping
 Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears
 Speech problems (if so what sounds _____) Mouthbreathing Awake _____ Asleep _____
Is there any other information which may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future.

Parent Signature

Date

Reviewed by