Patient Information

Date___________________

Name____ Date of birth_______________
Last First Middle

Address ____
Street City Zip

School ________________________ Grade_______

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

Responsible Party Information

Parent 1____ Date of birth_________ Relationship to Patient__________
Last First Middle

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Home Phone______________________ Cell Phone__________________ Email Address_________________________

Employer_____________________________ Occupation___________________ Social Security # _________________

Parent 2____ Date of birth_________ Relationship to Patient__________
Last First Middle

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Home Phone______________________ Cell Phone______________________ Email Address____________________

Employer_____________________________ Occupation___________________ Social Security # _________________

Dental Insurance Information

Insured's Name____ Insured's Social Security #___________________

Insurance Company_________________________ Group No._________________ Local No. _____________________

Insurance Co. Address____ Phone No. ___________________

Do you have dual coverage? No_____ Yes_____ If yes, please provide the information below:

Insured's Name____ Insured's Social Security #______________________

Insurance Company_________________________ Group No._________________ Local No. _____________________

Insurance Co. Address____ Phone No. ___________________

Emergency Information

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone ____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____

Updates (date & initial) ____

MEDICAL HISTORY

Child's Physician ____ Date of Last Visit ______________________________
Address ____ Phone ______________________________________

Please circle Yes or No (If Yes, please fill in details)

Is your child taking any medication? No Yes ____
Does your child have a history of a major illness? No Yes ____
Has your child ever had any major operations? No Yes ____
Has your child ever been involved in a serious accident? No Yes____

List any allergy or drug sensitivity that your child has (including latex, food, metals, etc.) _______________________________
____

Circle any of the medical conditions below that your child had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Does your child have any medical conditions that you feel Dr. Martines should be aware of?______________________
____

DENTAL HISTORY

Child's Dentist ____ Date of last visit ________________________________

What concerns you most about your child's teeth? ____

Yes No Has your child ever seen an orthodontist? If yes, who and when? ___________________________________
Yes No Has anyone in your family received orthodontic treatment? ____
How did they feel about the result? ____
What is your child's attitude about orthodontic treatment? ____

Yes No Is your child presently in any dental pain? ____
Yes No Has your child ever experienced any unfavorable reaction to dentistry? ______________________________
Yes No Has your child ever lost/chipped any teeth due to trauma/accident? _________________________________
Yes No Have there been any injuries to face, mouth or teeth? ____
Yes No Does your child have any type of thumb or tongue habit? ____
Yes No Is your child a mouth breather?____
Yes No Does your child grind or clench the teeth? ____
Yes No Are you aware that some appointments will be during school/work hours? _____________________________

Female Patients only

Yes No Has menstruation started? ____

UPDATES Medical and Dental History

Date __/__/__ ☐No changes ☐Changes ____

Date __/__/__ ☐No changes ☐Changes ____

Date __/__/__ ☐No changes ☐Changes ____

PLEASE READ

Orthodontics is a service that provides an improvement in the appearance of the teeth, in their general function and health. Teeth, gums and jaws are an intricate body part and at times fail to respond to treatment. If good oral hygiene is not practiced, dental decay and swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Because teeth change position throughout life, there can be some movement and change after treatment. I have read and understand this paragraph.

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Martines to perform a complete orthodontic evaluation of my child, including photographs and x-rays.

Signature: ____ Date:______________________