

**WELCOME TO
AMHERST ORTHODONTICS**

Child

Date: _____

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

CHILD'S NAME _____ Prefers to be called: _____ Date of Birth: _____ M / F

Mailing Address: _____ City: _____ State: _____ Zip: _____ Home Phone _____:

School: _____ Grade: _____ Age: _____

Hobbies / Sports / Interests: _____

Who is accompanying this child today? _____ Relationship to Patient: _____

Does this person have legal custody of the child? Yes No

Child's general dentist: _____ Date of last cleaning: _____ Pending dental work? _____

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

Please provide information of the parents/guardians with whom the child RESIDES:

Parents: Married Divorced Separated Other

MALE - Title, First, Last Name: _____ Relationship to patient: _____

Social Security Number: _____ Employer: _____

Occupation: _____ Work Phone: _____ Cell Phone _____

FEMALE-Title, First, Last Name: _____ Relationship to patient: _____

Social Security Number: _____ Employer: _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

If applicable, information of other parents/guardians:

Parents: Married Divorced Other

MALE - Title, First, Last Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____ Work Phone: _____

Employer: _____ Occupation: _____

FEMALE-Title, First, Last Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____ Work Phone: _____

Employer: _____ Occupation: _____

If biological parents do not reside together should each parent receive correspondence

Yes No

Family Facts

Brothers (with ages): _____

Sisters (with ages): _____

Have any family members received orthodontic treatment? _____ Please Name: _____

Have any relatives been treated in our office? _____ Please Name: _____

What are your chief orthodontic concerns? _____

Has your child ever been evaluated for, or previously had, orthodontic treatment? _____

Medical History:

Child's Physician: _____ Date of last exam: _____

Is your child in good health? _____ Does your child have to premedicate for dental visits? YES NO

Circle any of the following medical issues, which apply to your child:

Allergies	Hepatitis	Clenching/grinding teeth
Arthritis	HIV+/AIDS	Clicking/popping of jaw
Asthma	Jaundice	Jaw joint pain (TMJ)
Bleeding disorder	Migraines	Locking of jaw
Cancer	Pregnancy	Lip sucking/biting
Cold sores	Psychological issues	Mouth breather
Convulsions/epilepsy	Rheumatic fever	Nail biting
Diabetes	Sinus trouble	Snoring
Heart murmur	Tuberculosis (TB)	Speech problems
Heart disease	Venereal disease	Thumb sucking habit
		Tongue thrust

Does your child have a history of thumb or finger sucking? _____ If yes, until what approximate age? _____

Have the tonsils and/or adenoids been removed? _____

Has your child reached puberty? (Girls: Started menstruation; Boys: Voice changed) _____ At what age? _____

Have there been any injuries to the face, mouth, teeth or chin? If yes, describe injury and indicate age when occurred. _____

Please list any medications/drugs your child is currently taking.

Is your child allergic to any drugs, latex, or metals? If yes, please specify. _____

Please provide additional information on any above circled medical issues or any other conditions we should be aware of.

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

Signature