WELCOME TO AMHERST ORTHODONTICS!

CHILD

Our goal is to make everyone's visit pleasant and educational.
The contents of this questionnaire are strictly confidential and will become part of the dental record. Thank you for filling out the information below.

PATIENT INFORMATION

Child's Name:			☐ **M** ☐ **F**
Prefers to be called:	**Home Phone:**		
Mailing Address:	**City:**	**State:**	**Zip:**

How did you hear about us and whom may we thank for the referral? (*check box below*)

☐ **My hygienist** **Name: _____**
☐ **My dentist** **Name: _____**
☐ **My friend/coworker/neighbor** **Name: _____**
☐ **Your staff member referred me** **Name: _____**
☐ **A school visit by the doctors: _____**
☐ **Internet Search. keywords used: _____**
☐ **Newspaper. Which One?_____**
☐ **Other. Please explain:_____**

School:	**Grade:**	**DOB:**
Hobbies / Sports / Interests:		
Brothers:	**Sisters:**	
Who is accompanying this child today?	**Relationship to patient:**	
Does this person have legal custody of the child? **Yes** ☐ **No** ☐		

THE PARENTS / GUARDIAN WITH WHOM THIS PATIENT RESIDES:

Parents: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Partnered** ☐ **Widowed**

Title, First, Last Name:	**Relationship to patient:**	
Email:		
Cell Phone:	**Work Phone:**	
Occupation:	**Employer:**	
Title, First, Last Name:	**Relationship to patient:**	
Email:		
Cell Phone:	**Work Phone:**	
Occupation:	**Employer:**	

IF APPLICABLE, INFORMATION OF OTHER PARENTS/GUARDIANS:

Parents: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Partnered** ☐ **Widowed**

Title, First, Last Name:		**Relationship to patient:**	
Mailing Address:	**City:**	**State:**	**Zip:**
Preferred Phone:			
Title, First, Last Name:		**Relationship to patient:**	
Mailing Address (if different):	**City:**	**State:**	**Zip:**
Preferred Phone:			
IF BIOLOGICAL PARENTS DO NOT RESIDE TOGETHER, SHOULD EACH PARENT RECEIVE CORRESPONDENCE?			Yes ☐ No ☐

DENTAL HISTORY

Child's general dentist:	**Date of last cleaning:**	**Pending dental work? Yes ☐ No ☐**
What are your chief orthodontic concerns?		
Has your child ever been evaluated for, or previously had, orthodontic treatment?		
Has your child ever had a tooth extracted? Yes ☐ No ☐	**Name of dentist or oral surgeon who performed extraction:**	
What is your child's anxiety level during a dental appointment? Please check, 1 =none to 5= very high. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
If you checked 3 or greater, please explain:		

Have any family members received orthodontic treatment? Yes ☐ No ☐	**Please name:**
Have any relatives been treated in our office? Yes ☐ No ☐	**Please circle the names above that have been treated in our office.**
Does your child have to premedicate for dental visits? Yes ☐ No ☐	
Have there been any injuries to the face, mouth, teeth or chin? If yes, describe injury and indicate age when occurred.	

MEDICAL HISTORY

Child's Physician:	**Is your child in good health? Yes ☐ No ☐**
Date of last exam:	

Circle any of the following which apply to your child:

Allergies	Hepatitis	Clenching / Grinding teeth	Psychological issues	Tongue thrust	Sinus trouble	Cold sores
Arthritis	HIV+ / AIDS	Clicking / Popping of jaw	Convulsions/Epilepsy	Aspergers	Bone disorder	Snoring
Asthma	Jaundice	Jaw joint pain (TMJ)	Speech therapy	Tuberculosis (TB)	Nail biting	Diabetes
Bleeding disorder	Migraines	Locking of jaw	Thumb sucking habit	Rheumatic fever	Other:	
Cancer	ADHD	Lip sucking / Biting	Heart murmur / Disease	Mouth breather		

Does your child have a history of thumb or finger sucking? Yes ☐ No ☐	**If yes, until what approximate age?**
Have the tonsils and/or adenoids been removed? Yes ☐ No ☐	
Has your child reached puberty? (Girls: started menstruation; Boys: voice changed) Yes ☐ No ☐ Soon ☐	**At what age?**
Please list any medications / drugs your child is currently taking.	
Is your child allergic to any drugs, latex, metals, or local anesthesia (i.e.novocaine)? 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

_____

Date