Today's Date

PLEASE PRINT CLEARLY

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# Child Patient Information

| | | | | |
|---|---|---|---|---|
| PATIENT: Name (FIRST / MIDDLE INITIAL / LAST) | | Nickname | Birthdate / AGE | Sex |
| Home Address | City | Zip | Home Phone | |
| School | City | Grade | | |
| Sibling Name/Birthdate | | Sibling Name/Birthdate | | |
| Sibling Name/Birthdate | | Sibling Name/Birthdate | | |
| Other family members seen in our office | | Referred by | | |
| FATHER: Name | | Cell Phone | | |
| | | Email | | |
| Home Address | City | Zip | Home Phone | |
| Employer | | Occupation | | |
| Employer's Address | City | Zip | Work Phone | |
| MOTHER: Name | | Cell Phone | | |
| | | Email | | |
| Home Address | City | Zip | Home Phone | |
| Employer | | Occupation | | |
| Employer's Address | City | Zip | Work Phone | |

# Insurance Information

| | | | |
|---|---|---|---|
| PRIMARY DENTAL INSURANCE: Insured Member | | Social Security No. | Birthdate |
| Primary Insurance Company | | Phone | |
| Address | City | State | Zip |
| Insured's Employer | | Group No. | |
| SECONDARY INSURANCE: Insured Member | | Social Security No. | Birthdate |
| Secondary Insurance Company | | Phone | |
| Address | City | State | Zip |
| Insured's Employer | | Group No. | |
| WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT: | | | |
| Social Security No. | Home Phone | Work Phone | |
| Address | City | State | Zip |
| We accept responsibility for payment of all costs incurred with Carvalho & Roth Orthodontics. I understand that, where appropriate, Credit Bureau reports may be obtained | | | |
| Signature of Parent/Guardian | | Date | |

# Dental History

| | | |
|---|---|---|
| Patient's Dentist | City | Phone |
| Primary Concern | Date of last cleaning | |
| 1. Has there been previous orthodontic treatment? | ☐ Yes ☐ No | If yes, by whom? |
| 2. Have there been primary (baby) teeth removed by a dentist | ☐ Yes ☐ No | |
| 3. Is there or has there been a concern about periodontal (gum and bone) problems? | ☐ Yes ☐ No | |
| 4. Is there any UNUSUAL Dental History? | ☐ Yes ☐ No | If yes, please explain: |
| 5. Have any teeth been bumped or injured? | ☐ Yes ☐ No | If yes, please explain: |
| 6. Does the patient have a tendency to gag easily? | ☐ Yes ☐ No | |
| 6. Do any speech problems exist | ☐ Yes ☐ No | |

# Dental History *Continued*

8. Have you ever HAD or PRESENTLY HAVE any of the following:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Thumb Sucking | ☐ | ☐ | Lip Biting | ☐ | ☐ | Grinding or Clenching Teeth | ☐ | ☐ | Other |
| ☐ | ☐ | Finger Sucking | ☐ | ☐ | Nail Biting | ☐ | ☐ | Snoring | | | |
| ☐ | ☐ | Tongue Thrusting | ☐ | ☐ | Mouth Breathing | ☐ | ☐ | Smoking/Tobacco Chewing | | | |

9. Is the patient frightened or anxious about orthodontic treatment? ☐ Yes ☐ No

3. Is the patient concerned about the appearance of his/her teeth? ☐ Yes ☐ No

10. What aspect of orthodontic treatment are you most concerned about?

☐ Quality ☐ Cost ☐ Discomfort ☐ Length of Treatment

# Medical History

| Patient's Physician | City | Phone |
|---|---|---|
| | | |

1. Has the patient HAD or PRESENTLY HAVE any of the following:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Trouble | ☐ | ☐ | Tumors | ☐ | ☐ | Bleeding Disorders | ☐ | ☐ | Headaches |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Convulsions | ☐ | ☐ | Glaucoma | ☐ | ☐ | Cleft Lip or Palate |
| ☐ | ☐ | Artificial Heart Valve/Pacemaker | ☐ | ☐ | Epilepsy | ☐ | ☐ | Glandular Disorders | ☐ | ☐ | Jaw Clicking/Popping |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Cancer | ☐ | ☐ | Genetic Disorders | ☐ | ☐ | Jaw Stiffness/Locking |
| ☐ | ☐ | High/Low Blood Pressure | ☐ | ☐ | Sleep Disorders | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Jaw Soreness |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Hepatitis | ☐ | ☐ | Breathing Disorders | ☐ | ☐ | Other _____ |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Fainting/Dizziness | | | |
| ☐ | ☐ | Arthritis | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Emotional Problems | | | |

2. Is the patients health good at this time? ☐ Yes ☐ No

3. Is the patient under the care of a physician at this time? ☐ Yes ☐ No If yes, please explain:

4. Is the patient taking any medication(s) at this time? ☐ Yes ☐ No Name of medication(s):

5 Is the patient allergic to any medication(s)? ☐ Yes ☐ No Name of medication(s):

6. Does the patient have a latex allergy ☐ Yes ☐ No

7. Does the patient have a metal allergy? ☐ Yes ☐ No

8. Has the patient had tonsils and/or adenoids removed? ☐ Yes ☐ No

9. Has the patient had a serious illness or been hospitalized? ☐ Yes ☐ No If yes, please explain:

10. Has the patient ever been advised by their physician to take an antibiotic prior to any dental procedures? ☐ Yes ☐ No

If yes, antibiotic name and method:

11. Has the patient shown signs of increased growth recently? ☐ Yes ☐ No

Present growth rate ☐ Normal ☐ Rapid ☐ Slow ☐ None

12. Has the patient reached puberty? ☐ Yes ☐ No

13. Does the patient have a more than normal tendency toward having a cold, ear infection or sore throat? ☐ Yes ☐ No

14. Has the patient ever had a severe head or facial injury? ☐ Yes ☐ No If yes, please explain:

15. Has the patient ever taken any prescribed diet medication(s)? ☐ Yes ☐ No Name of medication(s):

16. Does the patient have any disease, condition, or problems not listed? ☐ Yes ☐ No If yes, please explain:

If yes, please explain:

Please use space below to provide any helpful information. Feel free to include any questions you may have:

I, the undersigned, have completed the health questionnaire and certify that the preceding information ins true and correct.
THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.
I grant authority to Carvalho & Roth to perform all procedures and treatments in the patient's best interest.

Member
American Association of
Orthodontists

Signature of Parent or Guardian Relationship to Patient Date