CARVALHO & ROTH
ORTHODONTICS
www.BracesOnLine.com

Child Patient Information

PATIENT: Name		Nickname	Birthdate	Sex
Home Address	City	Zip	Home Phone	
School	City	Grade		
Sibling Name/Birthdate		Sibling Name/Birthdate		
Other family members seen in our office		Referred by		
Parent Name		Cell Phone		
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer Address	City	Zip	Work Phone	
Parent Name		Cell Phone		
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer Address	City	Zip	Work Phone	

Insurance Information

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

Dental History

Patient's Dentist	City	Phone
Primary Concern	Date of last cleaning	
Has there been previous orthodontic treatment?		▢ Yes ▢ No If yes, by whom?
Have there been primary (baby) teeth removed by a dentist?		▢ Yes ▢ No
Is there or has there been a concern about periodontal (gum and bone) problems?		▢ Yes ▢ No
Is there andy UNUSUAL dental history?	▢ Yes ▢ No	If yes, please explain
Have any teeth been bumped or injured?	▢ Yes ▢ No	If yes, please explain
Is there a tendency to gag easily?		▢ Yes ▢ No
Do any speech problems exist?		▢ Yes ▢ No

Have you ever HAD or PRESENTLY HAVE any of the following habits:			
Yes No ▢ ▢ Thumb sucking ▢ ▢ Finger sucking ▢ ▢ Tongue thrusting	Yes No ▢ ▢ Lip biting ▢ ▢ Nail biting ▢ ▢ Mouth breathing	Yes No ▢ ▢ Grinding or clenching teeth ▢ ▢ Snoring ▢ ▢ Smoking/Tobacco Chewing	Yes No ▢ ▢ Other: _____ _____
If yes, when did the habit stop?			

Is the patient frightened or anxious about orthodontic treatment?	▢ Yes ▢ No
Is the patient concerned about the appearance of his/her teeth?	▢ Yes ▢ No
What aspect of orthodontic treatment concerns you? ▢ Quality ▢ Cost ▢ Discomfort ▢ Length of Treatment	

Medical History

Patient's Physician		City	Phone
Yes No ▢ ▢ Heart Trouble ▢ ▢ Heart Mumur ▢ ▢ Artificial Heart Valve ▢ ▢ Mitral Valve Prolapse ▢ ▢ High/Low Blood Pressure ▢ ▢ Rheumatic Fever ▢ ▢ Diabetes ▢ ▢ Arthritis ▢ ▢ Tumors	Yes No ▢ ▢ Tumors ▢ ▢ Convulsions ▢ ▢ Epilepsy ▢ ▢ Cancer ▢ ▢ Sleep Disorders ▢ ▢ Hepatitis ▢ ▢ Tuberculosis ▢ ▢ HIV/AIDS	Yes No ▢ ▢ Bleeding Disorders ▢ ▢ Glaucoma ▢ ▢ Genetic Disorders ▢ ▢ Glandular Disorders ▢ ▢ Kidney Disorders ▢ ▢ Breathing Disorders ▢ ▢ Fainting/Dizziness ▢ ▢ Emotional Problems	Yes No ▢ ▢ Headaches ▢ ▢ Cleft lip or Palate ▢ ▢ Jaw Clicking / Popping ▢ ▢ Jaw Stiffness / Locking ▢ ▢ Jaw Soreness ▢ ▢ Other _____ _____ _____

Is the patient's general health good at this time?	▢ Yes ▢ No	
Is the patient under the care of a physician at this time?	▢ Yes ▢ No	If yes, please explain.
Is the patient taking medication(s) at this time?	▢ Yes ▢ No	Name of medication(s):
Is the patient allergic to any medication(s)?	▢ Yes ▢ No	Name of medication(s):
Does the patient have a latex allergy?	▢ Yes ▢ No	
Does the patient you have a metal allergy?	▢ Yes ▢ No	
Has the patient had his/her tonsils and/or adenoids removed?	▢ Yes ▢ No	
Has the patient had a serious illness or been hospitalized?	▢ Yes ▢ No	If yes, please explain.
Has the patient been required to take antibiotic prophylaxis prior to dental treatment?	▢ Yes ▢ No	If yes, why and what medication?
Have you had a severe head or facial injury?	▢ Yes ▢ No	If yes, please explain.
Has the patient shown signs of increased growth lately?	▢ Yes ▢ No	If yes ▢ Rapid ▢ Normal ▢ Slow
Has the patient reached puberty?	▢ Yes ▢ No	
Does the patient have a more than normal tendency toward having a cold, an ear infection or sore throat?	▢ Yes ▢ No	
Has the patient ever had a severe head or facial injury?	▢ Yes ▢ No	If yes, please explain.
Has the patient ever taken any prescribed diet medication(s)?	▢ Yes ▢ No	Name of medication(s):
Does the patient have any disease, condition, or problems not listed?	▢ Yes ▢ No	If yes, please explain.
Please use the 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 is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF THE INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to Carvalho & Roth Orthodontics to perform all procedures and treatments in the patient's best interest.

_____Sign

ature of Parent or Guardian Relationship to Patient Date

Member American Association of Orthodontists