Child Patient Info

Date: ____________

Name: ______________________________ Nickname or name you prefer: ____________
Last First MI

Birthdate: ____________ Age: _____ Sex: ❍ M ❍ F Social Security: ____________

Address: ____
Street City State Zip

Date of last cleaning: ______________________________

How did you hear about us? ______________________________

School name: ______________________________

Does your child have any siblings?: ❍ Y ❍ N Names and ages: ____________

Primary Responsible Party

Name: ______________________________ Relationship to patient: ____________
Last First MI

Title (Mr, Mrs, Ms, Dr, etc.):____ Sex: ❍ M ❍ F Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed

Birthdate: ____________ Age: _____ Social Security: ____________ Driver's License: ____________

Address (if different from above): ______________________________
Street City State Zip

How long at this address? _____ Email: ______________________________

Home phone: ____________ Work phone: ____________ Cell phone: ____________

Best phone for reaching you during the day: ❍ Home ❍ Work ❍ Cell

Employer: ____________ Occupation: ____________ Years of employment: _____

Employer's address: ______________________________
Street City State Zip

Insurance company name: ____________ Insurance phone: ____________

Insurance address: ______________________________
Street City State Zip

Group name: ____________ Insurance ID# or SS#: ____________ Group ID#: ____________

Secondary Responsible Party

Name: ______________________________ Relationship to patient: ____________
Last First MI

Title (Mr, Mrs, Ms, Dr, etc.):____ Sex: ❍ M ❍ F Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed

Birthdate: ____________ Age: _____ Social Security: ____________ Driver's License: ____________

Address (if different from above): ______________________________
Street City State Zip

How long at this address? _____ Email: ______________________________

Home phone: ____________ Work phone: ____________ Cell phone: ____________

Best phone for reaching you during the day: ❍ Home ❍ Work ❍ Cell

Employer: ____________ Occupation: ____________ Years of employment: _____

Employer's address: ______________________________
Street City State Zip

Insurance company name: ____________ Insurance phone: ____________

Insurance address: ______________________________
Street City State Zip

Group name: ____________ Insurance ID# or SS#: ____________ Group ID#: ____________

(please complete other side)

NAPERVILLE DENTAL SPECIALISTS
& GENERAL ORAL HEALTH CARE

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GENERAL

Describe the primary concern with your child's teeth? ____________________

What is your child's attitude toward treatment? ❍ wants ❍ unwilling but agrees ❍ doesn't want

What is your child's school performance? ❍ above average ❍ average ❍ slow learner

DENTAL

❍ Y ❍ N Does your child require antibiotics for dental cleanings?

❍ Y ❍ N Are you aware that any dental work needs to be completed (ie: fillings)?

❍ Y ❍ N Is your child presently in any dental pain?

❍ Y ❍ N Has your child ever had trauma to the head, face or teeth? (if yes, please circle answer)

❍ Y ❍ N Does your child have any extra, missing or extracted teeth? (if yes, please circle answer)

❍ Y ❍ N Has your child ever had an unfavorable reaction to dentistry?

❍ Y ❍ N Does your child have TMJ problems (clicking/pain)?

❍ Y ❍ N Do any family members have a similar bite?

❍ Y ❍ N Have your child's adenoids/tonsils been removed?

❍ Y ❍ N Do you brush daily?

❍ Y ❍ N Do you have any gum problems?

❍ Y ❍ N Do you clench/grind your teeth?

❍ Y ❍ N Do you have any speech problems?

❍ Y ❍ N Floss daily?

❍ Y ❍ N Have a finger/thumb habit?

❍ Y ❍ N Have difficulty chewing?

❍ Y ❍ N Use any tobacco products?

MEDICAL

Please check any problems or conditions that may apply to your child:

❍ Abnormal bleeding/Hemophilia
❍ Anemia
❍ Asthma
❍ Bone disorder
❍ Cancer
❍ Diabetes
❍ Drug/alcohol use
❍ Endocrine
❍ Epilepsy
❍ Gastrointestinal
❍ Heart problem/defect
❍ Heart murmur
❍ Hepatitis/Liver
❍ Herpes/Fever blisters
❍ HIV/AIDS
❍ Jaundice
❍ Kidney
❍ Pre-Med Cancer
❍ Psychological/ADD/ADHD
❍ Respiratory Problems
❍ Rheumatic/Scarlet fever
❍ Sinus Problems
❍ Tuberculosis
❍ Tumor/Cancer

❍ Other ____________________

Has your child had any past surgeries? ❍ Y ❍ N If yes, what was the surgery? ____________________

Are your child's immunizations current? ❍ Y ❍ N

Do you have allergies to any medications or any other substance? ____________________

Are you allergic to Penicillin? ❍ Y ❍ N Are you allergic to Latex? ❍ Y ❍ N

List all medications currently being taken: ____________________

I have read and understand the above questions, and this office's privacy policies. I will not hold Innovative Orthodontic Centers responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes. I understand, where appropriate, credit bureau reports may be obtained.

____________________ Responsible party signature

____________________ Date