Child Form

Child's name______________________________ Age _________
Last First Middle

Address ______________________________
Street City Zip

Home Phone__________ Birthdate__________ Social Security #__________

Who is accompanying your child today? ______________________________

Whom may we thank for referring you to our office? ______________________________

Where does your child go to school? __________ Grade? __________

What are some of your child's favorite activities? ______________________________

Custodial *Parent* Information

Name ______________________________ Marital Status __________
Last First Middle

Residence______________________________ ☐ Own ☐ Rent
Street City Zip

Yrs at this address_____ Previous Address (if less than 3yrs)______________________________
Street City, St Zip

Mailing Address ______________________________
Street City Zip

Primary cell phone number__________ Work phone __________

Email address ______________________________

Social Security #__________ Birthdate__________ Relationship to Patient _______

Employer__________ Occupation__________ # Years Employed _______

Spouse's Name______________________________ Relationship to Patient__________

Employer__________ Occupation__________ # Years Employed ______

Social Security # __________ Birthdate __________ Work Phone __________

Dental Insurance Information

Insured 's Name______________________________ Insured's Social Security #__________

Insurance Company______________________________ Group No.__________

Insurance Co. Address______________________________ Phone No.__________

Policy Holder's Employer______________________________

Do you have **dual** coverage? Yes____ No____ If Yes:

Insured's Name______________________________ Insured's Social Security #__________

Insurance Company______________________________ Group No.__________

Insurance Co. Address______________________________ Phone No.__________

Policy Holder's Employer______________________________

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Benjamin Gregg to perform a complete orthodontic evaluation. I understand where appropriate, credit bureau reports will be obtained.

Signature: (Parents signature if minor)______________________________ Date:__________

Medical History

Physician ____________________ Date of Last Visit ____________

Please **circle** Yes or No (**If Yes**, please fill in details)

Yes No Are you taking any medication? ____________
Yes No Are you allergic to any medications? ____________
Yes No Are you currently under the care of a physician? ____________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Asthma or Hayfever	Fever Blisters	High Blood Pressure
Anemia	Diabetes	Heart Murmur	HIV/Aids
Arthritis	Epilepsy	Hepatitis/Liver problems	Prolonged Bleeding
			Radiation/Chemotherapy

Are there any medical conditions we have not discussed that you feel we should be aware of? ______
____

Dental History

General Dentist ____________________ Date of last visit ____________

What concerns you most about your teeth? ____________
Yes No Are you presently in any dental pain? ____________
Yes No Have you ever experienced any unfavorable reaction to dentistry? ____________
Yes No Have there been any injuries to face, mouth, or teeth? ____________
Yes No Do your gums bleed when you brush? ____________
Yes No Do you have any type of thumb or tongue habit? ____________
Yes No Are you a mouth breather? ____________
Yes No Have you ever seen an orthodontist? If yes, who and when? ____________
What is your attitude toward receiving orthodontic treatment? ____________
Yes No Has anyone in your family received orthodontic treatment? ____________
How did they feel about the result? ____________
Yes No Are you aware of your jaw clicking or popping? ____________
Yes No Have you ever been told that you clench or grind your teeth ____________
Yes No Do you have "tension" headaches? ____________
Female Patients only: Are you pregnant? Yes ____ No ____

Signature: (Parents signature if minor) ____________________ Date: ____________

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