

FOREVER SMILES

— ORTHODONTICS —

Pediatric Orthodontic Acquaintance & Health Form

Part I. Patient & Parent/Guardian Information

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Siblings? _____ Hobbies? _____

Main phone number: _____ Can this phone number receive text messages? Y or N

Parent/ guardian name: _____ Relation to patient: _____

Parent/ guardian email: _____ Occupation: _____

Add'l parent/ guardian name: _____ Occupation: _____

Does the patient have dental insurance? Y or N If yes, insurance company name: _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

Are you the person that will be financially responsible for this account? Y or N If not, who? _____

Part II. Medical History

Pediatrician: _____ City: _____ Last visit: _____

Please list the patient's medical condition(s) if any: _____

Please list any medication(s) taken by the patient: _____

Is the patient allergic to: Latex? Y or N Nickel? Y or N Medications? Y or N If yes, list: _____

Has the patient had any hospitalizations or surgeries in the last 5 years? Y or N If yes, list: _____

Part III. Dental History

Dentist: _____ City: _____ Last visit: _____

Does the patient have any pain in their mouth currently? Y or N If yes, explain: _____

Does the patient have a history of: Trauma to teeth or face? Y or N Thumb sucking? Y or N Mouth breathing? Y or N

Has the patient had prior orthodontic treatment? Y or N If yes, explain: _____

Has the patient had a prior orthodontic consultation? Y or N If yes, when & where? _____

What improvements would you like to see? _____

How did you hear about our office? _____

I have answered the questions on this form to the best of my knowledge _____
and I have been informed of the Notice of Privacy practices of this office. Parent/ Guardian Signature