

SMILE ART ORTHODONTICS
New Patient Information (MINOR PATIENT)

Welcome! Please assist us in your child's treatment by filling this form out accurately and completely. Thank you.

Patient's Name (Last, First, MI): _____ Date (mm/dd/yy): _____
Prefers to be called: _____
Birth date: _____ Age: _____ Gender: Male Female
Home address: _____
Home phone #: _____ Email: _____
School: _____ Grade: _____
Hobbies/Sports/Musical inst.: _____
Names and ages of siblings: _____
Any other family members seen at our office?: _____
Whom may we thank for referring you? _____
General / Pediatric dentist: _____
Tel#: _____ Approximate date of last visit: _____

(For the parent information following, write "same" in applicable areas if information is same as patient's information above)

Parent information #1

Please select: Mother Father Step-mother Step-father Guardian
Name (Last, First, MI): _____
Birth date: _____ Gender: Male Female
Home address: _____
Tel #: Home: _____ Work: _____ Cell: _____
Occupation: _____ Email: _____
Marital Status: Single Married Divorced Separated Widowed
If married, spouse's name: _____

Parent information #2

Please select: Mother Father Step-mother Step-father Guardian
Name (Last, First, MI): _____
Birth date: _____ Gender: Male Female
Home address: _____
Tel #: Home: _____ Work: _____ Cell: _____
Occupation: _____ Email: _____
Marital Status: Single Married Divorced Separated Widowed
If married, spouse's name: _____

Who is financially responsible for the account?: _____
Who should be contacted for scheduling/confirming?: _____

Patient's Name (Last, First, MI): _____

Medical History

Physician's Name, City and State: _____

Phone #: _____ Approximate Date of last visit: _____

Is child currently under the care of a physician? Yes No

If yes, please explain: _____

Is child taking any prescription/over-the-counter drugs? Yes No

If yes, please specify and explain reason: _____

Does child have a history of any major illness/hospitalization? Yes No

If yes, please explain: _____

Does child use any tobacco products? Yes No If yes, what and how often? _____

Does child have / has ever had / been treated for any of the following? Please select all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart surgery/pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV+/Aids |
| <input type="checkbox"/> Auto-immune disease | <input type="checkbox"/> Hospitalized for any reason |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Cancer/chemotherapy | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Canker sores / oral aphthous ulcers | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Cold sores/fever blisters/oral herpes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Drug/alcohol abuse | <input type="checkbox"/> Severe/frequent headaches |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sickle cell disease/traits |
| <input type="checkbox"/> Epilepsy/seizures/convulsions | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Fainting/dizziness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hearing loss/impairment | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Venereal disease |

Please list any drugs/materials that child is allergic to: _____

Patient's Name (Last, First, MI): _____

Dental History

Chief concern: _____

- Has child ever had or been evaluated for orthodontic treatment? Yes No
- Has child ever had a serious/difficult problem with any previous dental work? Yes No
- Does child have or has ever had pain/discomfort in the jaw joint (TMJ/TMD)? Yes No
- Has child ever had injury to (check all applicable): Mouth Teeth Chin Face
- Does child have any speech problems? Yes No
- Does child generally breathe through the mouth? Yes No
 - If yes, please select applicable: While awake While asleep
- Does child have habit of thumb/finger sucking?: Yes No
- Have you ever been told that your child has tongue thrust?: Yes No
- Does child clench/grind teeth? Yes No
- Does child have any missing or extra permanent teeth to your knowledge? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical and/or dental health status.

Parent / Guardian Signature

Date

Relationship to child

