Richards ORTHODONTICS

Child Patient Information

Name:_____ MALE

Preferred Name:_____ Birthdate:_____ Age:_____

Address:_____City:_____Zip:_____

Phone # where child resides:_____ Email:_____

School Attending:_____ Grade:_____

Parent's Name(s):_____

Parent's Cell Phone#(s)_____

Patient lives with: (Circle One)

☐ Mom ☐ Dad ☐ Mom & Step-Dad ☐ Dad & Step-Mom ☐ Grandparent(s) ☐ Legal Guardian

Child's general dentist:_____Last Cleaning Date:_____

Responsible Party/Adult Patient Information

Name:_____ MALE

Preferred Name:_____ If married, spouse's name:_____

Address:_____

E-Mail Address:_____

Home Phone#:_____ Cell#:_____

Work Phone#:_____ Employer:_____

Birthday:_____ SS#:_____

Family Dentist:_____ Last Cleaning Date:_____

Dental Insurance Information

☐ No Dental/Orthodontic Insurance (check box)

Primary Insured's Name:_____ Birthdate:_____

Address:_____ City:_____ Zip:_____

SS#:_____ Relation to patient:_____

Insurance Company:_____ Employer:_____

Insurance phone#:_____

DO YOU HAVE DUAL COVERAGE? YES

If yes:

Insured's name:_____ Birthdate:_____

Address:_____ City:_____ Zip:_____

SS#:_____ Relation to patient:_____

Insurance Company:_____ Employer:_____

Insurance phone#:_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE!

MEDICAL HISTORY

◯Yes ◯No Currently being treated by physician? Reason_____
◯Yes ◯No Currently taking medication? Reason_____
◯Yes ◯No Allergies? List:_____
◯Yes ◯No Allergic to Nickel?
◯Yes ◯No Allergic to Latex?
◯Yes ◯No Is there any past or current medical condition that we should be aware of?
Explain:_____

Please select if Patient HAS or HAD any of the following:

☐Asthma ☐Tonsils Removed? Age:_____ ☐Adenoids Removed? Age:_____

☐Mouthbreathing: While Awake

DENTAL HISTORY

◯Yes◯No Has the patient had any severe head or face injuries?
Explain:_____

◯Yes◯No Has the patient had a history of thumb habit or finger habit?
Stopped?_____ When?_____

◯Yes◯No Does the patient play any musical (wind) instruments?
What?_____

◯Yes◯No Has the patient consulted an orthodontist previously?
If Yes, who was the orthodontist?_____
When?_____

◯Yes◯No Have any siblings had orthodontic treatment? _____
If Yes, who was their orthodontist?_____
When did they have treatment?_____

◯Yes◯No Did either parent have orthodontic treatment?

Please select if there is a history of:

☐Clenching/grinding teeth ☐Jaw Joint Clicking/popping ☐Headaches (more than normal)

☐Jaw Joint Soreness ☐Ringing in the ears ☐Muscular soreness around head and neck

Who may we thank for referring you to our office?_____

Parent/Guardian Signature:_____ Date:_____

Print Form