Orthodontic Center

of Orange County

CHILD'S INFORMATION

Today's Date: _____

Child's Name _____ Birthdate: _____ Age _____
Address: _____
Tel #: _____ Social Security #: _____
Email: _____
School: _____ Grade: _____
Hobbies (Sports, Dance, Music, Acting, Skating, Instruments, Outdoor Activities):
_____
Names and ages of siblings: _____
Is there a specific problem or reason for your visit today? _____
Who may we thank for referring you to our office? _____

PARENT'S INFORMATION

Marital Status: _____
Mother's Name: _____ Birthdate: _____
Occupation: _____ Employer: _____
Social Security #: _____ Work Tel. #: _____
May we contact you at work? Y N

Father's Name: _____ Birthdate: _____
Occupation: _____ Employer: _____
Social Security #: _____ Work Tel. #: _____
May we contact you at work? Y N

DENTAL INSURANCE INFORMATION

Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Tel. #: _____ Group Number: _____
Person Insured: _____
Person Responsible for Account: _____

MEDICAL AND DENTAL HISTORY

Child's Dentist: _____ City: _____
Tel. #: _____ Last Visit to the Dentist: _____
Child's Physician: _____City: _____
Tel. #: _____

Has your child had any major illness, surgery, medical problems? ___ Yes ___ No
List (if applicable)

_____
List any medications your child is currently taking: _____
List any medications your child is allergic to: _____
List any other allergies (latex gloves, metals, etc.):_____
Is your child currently in good health? ___ Yes ___ No
Does your child require antibiotics prior to having routine dental treatment?
___Yes ___No

Has your child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	HIV+/AIDS
Y N	Diabetes	Y N	Kidney / Liver Problems
Y N	Blood Transfusion	Y N	Tuberculosis (TB)
Y N	Hepatitis	Y N	Asthma
Y N	Rheumatic / Scarlet Fever	Y N	Bone Disorders
Y N	Heart Defect / Murmur	Y N	Nervous Disorders
Y N	Cancer	Y N	Epilepsy / Convulsions

Has your child experienced any injuries to your face, mouth, teeth, or chin?
___ Yes ___ No
Are you aware of any missing or extra permanent teeth? ___ Yes ___ No
Have you had any jaw joint (TMJ) symptoms or problems? ___ Yes ___ No
Has puberty begu? ___ Yes ___ No
Has menstruation begun? ___ Yes ___ No

Are you aware of any of the following conditions?

Y N	Grinding / Clenching Teeth	Y N	Tongue Thrusting
Y N	Mouth Breather	Y N	Thumb/ Finger Sucking
Y N	Speech Problems	Y N	Lip Sucking / Biting

_____ _____
Parent's Signature Date