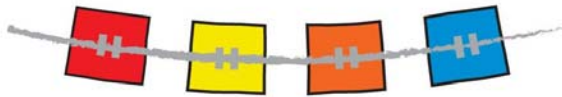


Orthodontic Center



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 begun?

___ 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