



Nicole Connors Smith  
—DMD • MSD—  
ORTHODONTICS

WELCOME TO OUR OFFICE

Today's Date: \_\_\_\_\_

So that we become better acquainted, please complete both sides of this form.

CHILD OR ADOLESCENT PATIENT HISTORY

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ ZIP: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Phone Number \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Siblings names and ages: \_\_\_\_\_

PARENTS AND ACCOUNT INFORMATION

Parents Marital Status: \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Widowed \_\_\_Single

FATHER

MOTHER

Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home Phone (if different from above): \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

If you have orthodontic Insurance coverage, please fill out below:

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

If other than parent:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(Over)

# Dental and Medical History

What are the main concerns you would like orthodontics to accomplish? \_\_\_\_\_

Has your child ever been evaluated for orthodontic treatment before? Yes No  
 Have there been any injuries to the face, mouth, teeth or chin? Yes No  
 Does the child require antibiotics before dental treatment? Yes No  
 Have adenoids or tonsils been removed? Yes No  
 Does your child have any missing or extra permanent teeth? Yes No  
 Has your child ever had any pain/tenderness in his/her jaw joint? (TMJ/TMD)? Yes No  
 Does the child brush his/her teeth daily? Yes No  
 Does the child floss his/her teeth daily? Yes No  
 Child's Physician: \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Child's height: \_\_\_\_\_ Weight: \_\_\_\_\_ Mother's height: \_\_\_\_\_ Father's height: \_\_\_\_\_  
 Is the child currently under the care of a physician? Yes No  
 Has puberty begun Yes No  
 For girls – Has menstruation begun Yes No  
 Please describe the child's physical condition:    Good    Fair    Poor  
 Please list all drugs the child is currently taking and why: \_\_\_\_\_

Is your child allergic to:    Latex                      Yes    No  
    Nickel/Metals                      Yes    No  
    Plastic                                Yes    No  
 Aside from the items listed above, list all drugs/things your child is allergic to: \_\_\_\_\_

## Has your child experienced any of the following medical problems?

<p>             Y N    Abnormal Bleeding              Y N    ADD/ADHD              Y N    Any Hospital Stays/Operations              Y N    Artificial Bones/Joints/Valves              Y N    Asthma              Y N    Cancer              Y N    Congenital Heart Defect              Y N    Convulsions              Y N    Diabetes              Y N    Epilepsy              Y N    Handicaps/Disabilities           </p>	<p>             Y N    Hearing impairment              Y N    Heart Murmur              Y N    Hepatitis              Y N    Kidney Problems              Y N    Liver Problems              Y N    Mitral Valve Prolapse              Y N    Prosthetics              Y N    Rheumatic Fever              Y N    Scarlet Fever              Y N    Sickle Cell Disease/Traits              Y N    Tuberculosis (TB)           </p>
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Has the child ever taken any diet pills such as Phen-Fen?                      Yes    No  
 (Also known as Redux or Pondimin) if so, when? \_\_\_\_\_  
 Are the child's immunizations current?    Yes    No  
 Is there anything you would like to discuss with the doctor in private?    Yes    No  
 Please discuss any serious medical problem the child has had: \_\_\_\_\_

Does/did the child experience any of the following?

Y N    Clenching/Grinding Teeth	Y N    Nursing Bottle Habits
Y N    Lip Sucking/Biting	Y N    Speech Problems
Y N    Mouth Breather	Y N    Thumb

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Dr. Smith to release all information necessary to secure the payment of benefits and I assign directly to Dr. Smith all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submission, whether manual or electronic.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Office use only

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein: \_\_\_\_\_

Signature of Dentist

Date

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