



PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

CHILD'S NAME: _____ Nick Name: _____ Date: _____
Last First Middle
Birthdate: _____ Age: _____ Male Female Home Phone #: _____
Address: _____
Street City State Zip
Sports/Hobbies: _____ Child's Email: _____
School: _____ Grade: _____ List brothers / sisters with age: _____

Who is accompanying your child today? _____ Relation _____ Do you have legal custody of this child? Yes No
Whom may we thank for referring you to our office? _____

PARENT INFORMATION

MOTHER'S INFORMATION: Mother Step Mother Guardian Other _____ Social Security #: _____ - _____ - _____
Name: _____ Birthdate: _____ Email: _____
Last First Middle
Mailing Address: _____
Street City State Zip
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Employer Name and Address: _____ Occupation: _____

FATHER'S INFORMATION: Father Step Father Guardian Other _____ Social Security #: _____ - _____ - _____
Name: _____ Birthdate: _____ Email: _____
Last First Middle
Mailing Address: _____
Street City State Zip
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Employer Name and Address: _____ Occupation: _____

Parents Marital Status: Married Single Divorced Separated Widowed Partnered

Person responsible for account: _____ Relation to patient: _____
Mailing Address: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Email: _____

DENTAL INSURANCE INFORMATION

Do you have orthodontic coverage? Yes No (If no, skip to next section)

PRIMARY ORTHODONTIC INSURANCE Insured's Name : _____ Birthdate: _____
Insurance Company Name: _____ Group #: _____ ID #: _____
Insurance Co. Address: _____ Phone #: _____
Do you have dual coverage? Yes _____ No _____

SECONDARY ORTHODONTIC INSURANCE Insured's Name: _____ Birthdate: _____
Insurance Company Name: _____ Group #: _____ ID #: _____
Insurance Co. Address: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relation to Patient: _____

MEDICAL HISTORY

| | |
|-------------------------|---------------------------|
| PHYSICIAN: _____ | Date of Last Visit: _____ |
| Address: _____ | Phone #: _____ |

ALLERGIES:

Yes No Is your child allergic to any latex, metals, nickel or plastics? *Please list:* _____

Yes No Is your child allergic to any medication / things? *Please list:* _____

Has your child ever had any of the medical conditions listed below: Yes _____ No _____ *If yes, please circle:*

| | | | | |
|--------------------------------|-------------------------|----------------------------|-------------------------|--------------------------|
| Abnormal Bleeding | Bone Disorders | Gastrointestinal Disorders | High/Low Blood Pressure | Psychiatric Problems |
| ADD or ADHD | Cancer/Tumor | Hearing Impairment | HIV/AIDS | Radiation/Chemotherapy |
| Anemia | Congenital Heart Defect | Heart Problems/Murmur | Kidney Problems | Rheumatic Fever |
| Artificial Bones/Joints/Valves | Diabetes | Hemophilia | Nervous Disorders | Severe/Frequent Headache |
| Asthma | Dizziness | Hepatitis/Liver Problems | Pneumonia | Sinus Problems |
| Autism | Epilepsy/Seizures | Herpes/Fever Blisters | Prolonged Bleeding | Tuberculosis |

Is your child taking any medication? *Please list:* _____

Is there a history of a major illness? *Please list:* _____

Has your child had any operations or been involved in a serious accident? *Please list:* _____

Are there any handicaps/disabilities that we should be aware of? _____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

| | |
|-------------------------------|---------------------------|
| GENERAL DENTIST: _____ | Date of Last Visit: _____ |
|-------------------------------|---------------------------|

What concerns you most about your child's teeth? _____

Has your child ever had any of the habits listed below: Yes _____ No _____ *If yes, please circle:*

| | | | | |
|-----------------|----------------------|-------------|-----------------|--------------|
| Clenching Teeth | Thumb / Finger Habit | Lip Sucking | Mouth Breathing | Nail Biting |
| Grinding Teeth | Tongue Thrust | Lip Biting | Speech Problems | Bottle Habit |

Yes No Has your child ever been evaluated for orthodontic treatment? _____

Yes No Is your child sensitive or self-conscious about his/her teeth? _____

Yes No Has anyone in the family received orthodontic treatment? _____

If yes, how did they feel about the result? _____

Yes No Has your child ever experienced any unfavorable reaction to dentistry? _____

Yes No Is your child presently in any dental pain? _____

Yes No Is any part of your child's mouth sensitive to temperature or pressure? *Where?* _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Has your child been informed of any missing or extra teeth? _____

Yes No Has your child ever lost or chipped any permanent teeth? _____

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____

Yes No Does your child ever experience jaw clicking or popping? _____

Yes No Does your child experience "tension" headaches? _____

Yes No Does your child brush daily? _____

Yes No Do gums bleed when brushing? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my child's medical or dental history. I understand that diagnostic records may be used for educational and promotional purposes. In addition, I authorize Dr. Jay Decoteau and staff to perform the necessary dental services my child needs.

Parent/Guardian Signature: _____ Date: _____

I understand that I am responsible for payment of services rendered and also for paying any co-payments and deductibles that my insurance does not cover. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/Guardian Signature: _____ Date: _____

This office reserves the right to verify the credit status of patients and/or their parents prior to extending credit for orthodontic fees and may, at the discretion of the office, use the services of credit reporting services.

Parent/Guardian Signature: _____ Date: _____