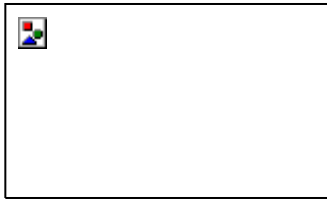


Child New Patient Form



Date _____

PATIENTS NAME _____ **PREFERRED NAME** _____

Gender: Male Female BIRTHDATE _____ SCHOOL _____ GRADE _____

ADDRESS (Mailing) _____ CITY _____ STATE _____ ZIP _____

Appointment Reminders: Text Message # _____ E-Mail Address _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party	
MOTHER'S NAME _____	FATHER'S NAME _____
<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian	<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian
D.O.B. _____ S.S.# _____	D.O.B. _____ S.S.# _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____
HOME PHONE _____	HOME PHONE _____
CELL PHONE _____	CELL PHONE _____
EMPLOYED BY _____	EMPLOYED BY _____
OCCUPATION _____	OCCUPATION _____
WORK PHONE _____	WORK PHONE _____
EMAIL _____	EMAIL _____
<input type="checkbox"/> Married <input type="checkbox"/> Divorced If divorced, may we communicate with both parents? _____	

Who will be Financially Responsible: _____

DENTAL INSURANCE INFORMATION ONLY

**Insurance can only be verified with a Social Security number and Date of Birth*

Primary Insurance

POLICY HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ DATE EMPLOYED _____

INSURANCE COMPANY _____ ID # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE PHONE# _____

Secondary Insurance

POLICY HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ DATE EMPLOYED _____

INSURANCE COMPANY _____ ID # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE PHONE# _____

PATIENT'S NAME _____

PATIENT'S DENTIST _____ Phone _____ Address _____

PATIENT'S PHYSICIAN _____ Phone _____ Address _____

PATIENT MEDICAL HISTORY

- | | | |
|---|-----|-----|
| | YES | NO |
| 1. Are you under medical treatment now? | ___ | ___ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | ___ | ___ |
| 3. Are you taking any medication(s) including Non-prescription medicine? If yes, what medication(s) are you taking? _____ | ___ | ___ |
| 4. Do you use tobacco? | ___ | ___ |
| 5. Do you use alcohol, cocaine or other drugs? | ___ | ___ |
| 6. Are you wearing contact lenses? | ___ | ___ |

7. Are you allergic to or have you had any reactions to **medications, latex or metals**? (Eg: aspirin, penicillin, sulfa drugs, etc.) If yes, what? _____

8. Women ONLY: Yes No
a) Are you pregnant or think you may be pregnant? ___ ___

*Please comment any other significant information about the patient's medical history: _____

Habits:

- | | | |
|-----|-----|---------------------------|
| YES | NO | |
| () | () | Clenching/ Grinding Teeth |
| () | () | Lip Sucking |
| () | () | Mouth Breather |
| () | () | Nail Biting |
| () | () | Thumb/finger sucking |
| () | () | Nursing bottle habits |

PATIENT DENTAL HISTORY

- | | | |
|---|-----|-----|
| | YES | NO |
| 1. Do your gums bleed while brushing or flossing? | ___ | ___ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ___ | ___ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ___ | ___ |
| 4. Do you feel pain to any of your teeth? | ___ | ___ |
| 5. Do you have any sores or lumps in or near your mouth? | ___ | ___ |
| 6. Have you had any head, neck, or jaw injuries? | ___ | ___ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking | ___ | ___ |
| b) Pain (joint, ear, side of face)? | ___ | ___ |
| c) Difficulty in opening or closing? | ___ | ___ |
| d) Difficulty in chewing? | ___ | ___ |

- | | | |
|---|-----|-----|
| | YES | NO |
| 8. Do you have frequent headaches? | ___ | ___ |
| 9. Do you clench or grind your teeth? | ___ | ___ |
| 10. Do you bite your lips or cheeks? | ___ | ___ |
| 11. Have any wisdom teeth been removed? How many? _____ | ___ | ___ |
| 12. Have you had any orthodontic work? _____
If yes, when _____
If yes, doctor's name _____ | ___ | ___ |
| 13. Have you ever had treatment for a periodontal disease (gum disease)? _____ | ___ | ___ |
| 14. Have your jaws ever "locked" CLOSED? If yes, describe _____ | ___ | ___ |
| 15. Have your jaws "locked" wide OPEN? If yes, describe _____ | ___ | ___ |

GROWTH AND DEVELOPMENT

- | | | |
|-----|-----|---|
| YES | NO | |
| ___ | ___ | Are there any learning disabilities? If yes, explain _____ |
| ___ | ___ | Has any other member of the family had orthodontic treatment? _____ |
| ___ | ___ | Has any other member of the family been a patient in this office? Name: _____ |

Please describe why you sought this consultation _____

*****We will be taking (2) x-rays and pictures at Orthodontic Appointment. Please check with patient's Dentist if a Panoramic Dental or Cephalometric x-ray was done with-in a year. If yes please bring to appointment or have them email to info@pachterortho.com.**

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

X _____
(Signature of Responsible Adult) _____ Date _____

Doctor's Notes _____

