OWENS-BAKER
ORTHODONTICS

CHILD

Patient Information

Patient's Name_____ Preferred Name_____ □ Male □ Female
Address_____ City_____ State_____ Zip_____
Birthdate_____ Age____ School_____ Grade_____ General Dentist_____
Date of last checkup?_____ Pts. Hobbies/Special Interests_____
Whom may we thank for recommending our office to you?_____
Accompanied by:_____ Relationship:_____

Responsible Party Information

Parents marital status: □ Married □ Separated □ Divorced □ Widowed □ Single
Name of Responsible Party_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Cell Carrier_____
Work Phone_____ Ext_____ Email_____
Preferred Correspondence (check all that apply): □ Mail □ Email □ Text SS#_____ Birthdate_____
Employer_____ Occupation_____ No. Years Employed_____

IF MARRIED:
Spouse's Name_____ Spouse's Employer_____
No.Years Employed_____ Occupation_____ SS#_____ Work Phone_____
Is the patient covered by orthodontic insurance? □ Yes □ No

Emergency Information

Name of nearest relative not living with you_____ Relationship_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____

Health History

Is patient in good health?	□ YES □ NO	Explain:_____
Any major or unusual illnesses?	□ YES □ NO	Explain:_____
Is patient under a physician's care?	□ YES □ NO	Reason:_____
Is patient currently taking medication?	□ YES □ NO	Reason:_____
Allergies?	□ YES □ NO	List:_____
Drug sensitivity?	□ YES □ NO	List:_____

Please check box if patient currently has, or has a history of any of the following:

□ Anemia
□ Asthma
□ ADHD/hyper activity
□ Behavioral problems
□ Bone disorders
□ Diabetes
□ Fever blisters/Herpes
□ Glaucoma
□ Handicaps/Disabilities
□ Heart problems
□ Hepatitis
□ HIV (tested positive)/AIDS
□ Latex Allergy
□ Tobacco use
□ Frequent Colds or Flu
□ Removal of tonsils: Age:_____
□ Removal of adenoids: Age:_____
□ Mouthbreathing: While awake?_____ While asleep?_____

Names & ages of brothers and sisters?_____
Have any family members had orthodontic treatment?_____ If so, who?_____

Dental History

Has the patient had any severe head or face injuries? □ Yes □ No If so, explain:_____
Has the patient had a history of thumb sucking or finger sucking? □ Yes □ No If so, has patient stopped sucking? When?_____
Does the patient play any musical (wind) instruments? □ Yes □ No If so, what?_____
Has the patient consulted with an orthodontist previously? □ Yes □ No If so, who?_____
Has the patient had any previous orthodontic treatment? □ Yes □ No

Please check box if patient has a history of any of the following:

□ Clenching Teeth
□ Grinding Teeth
□ Muscular Soreness around Head and Neck
□ Headaches (more than normal)
□ Ringing in the ears
□ Jaw Joint Popping
□ Jaw Joint Soreness
□ Jaw Joint Clicking

Responsible Party's Signature:_____ Date:_____
**I understand that where appropriate, credit bureau reports may be obtained.*

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____