OWENS-BAKER
ORTHODONTICS

Child Patient Information

Patient's Name__________ Preferred Name__________ ☐ Male ☐ Female

Home 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?__________

Names & ages of brothers and sisters?__________

Have any family members had orthodontic treatment?__________ If so, who?__________

Accompanied by:__________ Relationship:__________

Responsible Party Information

Parents marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Father/Guardian Information *Responsible for Account:* ☐ Yes ☐ No

Name:__________ Birthdate:__________ SS#__________

Address:__________ City:__________ State:__________ Zip:__________

Home Phone:__________ Work Phone:__________ Cell Phone:__________

Cell Carrier:__________ Email:__________ Preferred Correspondence: ☐ Mail ☐ Email ☐ Text

Employer:__________ Occupation:__________ Yrs Employed:__________

Mother/Guardian Information *Responsible for Account:* ☐ Yes ☐ No

Name:__________ Birthdate:__________ SS#__________

Address:__________ City:__________ State:__________ Zip:__________

Home Phone:__________ Work Phone:__________ Cell Phone:__________

Cell Carrier:__________ Email:__________ Preferred Correspondence: ☐ Mail ☐ Email ☐ Text

Employer:__________ Occupation:__________ Yrs Employed:__________

Dental Insurance Information

Primary

Subscriber's Name:__________ DOB:__________ ID or SS#__________

Subscriber's Address:__________

Employer:__________ Insurance Co. Name:__________

Insurance Phone#__________ Relationship to Patient:__________

Secondary

Subscriber's Name:__________ DOB:__________ ID or SS#__________

Subscriber's Address:__________

Employer:__________ Insurance Co. Name:__________

Insurance Phone#__________ Relationship to Patient:__________

Emergency Contact Information

Emergency Contact Name:__________ Relationship__________

Home Phone:__________ Cell Phone:__________

Child - 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 ☐ Bone disorders ☐ Handicaps/Disabilities ☐ Latex Allergy

☐ Asthma ☐ Diabetes ☐ Heart problems ☐ Tobacco use

☐ ADHD/hyper activity ☐ Fever blisters/Herpes ☐ Hepatitis ☐ Frequent Colds or Flu

☐ Behavioral problems ☐ Glaucoma ☐ HIV (tested positive) AIDS ☐ Removal of adenoids: Age:__________

☐ Mouthbreathing: While awake?__________While asleep?__________ ☐ Removal of tonsils: Age:__________

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?_______ 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 If so, when?____________________

By whom?____________________

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

☐ Clenching Teeth ☐ Headaches (more than normal) ☐ Jaw Joint Popping ☐ Grinding Teeth

☐ Ringing in the ears ☐ Jaw Joint Soreness ☐ Jaw Joint Clicking ☐ Muscular Soreness around Head and Neck

Smile Questionnaire

To evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all that apply):

Too small or short? NO YES

Too large or long? NO YES

Crooked or crowded? NO YES

Misshaped (uneven/pointed? NO YES

Off Color? NO YES

Do you feel your front teeth "stick out too much" (buck teeth)? NO YES

Are there spaces between your teeth that you do not like? NO YES

Does too much or too little gum tissue show when you smile? NO YES Explain:____________________

What are your chief concerns that you want orthodontics to address? Please indicate your goals and expectations of orthodontic treatment. (Explain in detail)____________________

____

____

Responsible Party's Signature:____________________Date:____________________