ORTHODONTICS

For Children & Adults

John A. Freeman D.D.S., M.S.D.

Welcome to our practice . . . please tell us about your child!

Today's Date:_____

PATIENT'S NAME (LAST, FIRST, INITIAL)	PREFERRED FIRST NAME	BIRTHDATE	SEX ☐ MALE ☐ FEMALE
STREET ADDRESS	CITY	ZIP	HOME PHONE NO.
PATIENT LIVES WITH ☐ MOTHER ☐ OTHER (DESCRIBE) ☐ BOTH PARENTS ☐ FATHER		SCHOOL PATIENT ATTENDS	GRADE
IN CASE OF EMERGENCY, NOTIFY (NAME)	PHONE	RELATIONSHIP TO PATIENT	HOBBIES & SPORTS (optional)
WHO MAY WE THANK FOR REFRRING YOU? ☐ DENTIST ☐ FAMILY MEMBER ☐ FRIEND ☐ SIGN ☐ YELLOW PAGES ☐ OTHER (DESCRIBE):			
DENTIST'S NAME	WHEN LAST VISITED (approximate)	PHYSICIAN'S NAME	WHEN LAST VISITED (approximate)
FREQUENCY OF DENTAL CHECKUPS ☐ TWICE A YEAR ☐ ONCE A YEAR ☐ ONLY IF THERE'S A PROBLEM ☐ NEVER			FREQUENCY OF FLOSSING EACH WEEK?

Office Notes:

- PLEASE COMPLETE THE SECTION BELOW.
- THE SECTION AT THE RIGHT IS FOR A SPOUSE OR OTHER PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT'S ACCOUNT

RESPONSIBLE PARTY, CUSTODIAL PARENT, OR LEGAL GUARDIAN

NAME (LAST, FIRST, INITIAL)		
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)		
CITY	STATE	ZIP
HOME PHONE NO. (IF DIFFERENT)	WORK PHONE NO.	
OCCUPATION	EMPLOYER	
WORK ADDRESS		
CITY	STATE	ZIP
RELATIONSHIP TO PATIENT (MOTHER, FATHER, ETC.)		

DENTAL INSURANCE INFORMATION

BIRTHDATE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.
INSURANCE CO. NAME	GROUP NO. (IF KNOWN)
INSURANCE CO. STREET ADDRESS	
CITY	STATE ZIP
INSURANCE CO. PHONE NO.	

May we bill insurance for you? ☐ Yes ☐ No

*Signature:*_____

For Office Use Only	
ORTHO INS? ☐ YES ☐ NO	RECORDS SEP? ☐ YES ☐ NO
ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

RESPONSIBLE PARTY, CUSTODIAL PARENT, OR LEGAL GUARDIAN

NAME (LAST, FIRST, INITIAL)		
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)		
CITY	STATE	ZIP
HOME PHONE NO. (IF DIFFERENT)	WORK PHONE NO.	
OCCUPATION	EMPLOYER	
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ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

Health & Dental History

1. Does your child have a health problem? ☐ Yes ☐ No
2. Is your child under treatment by a physician? ☐ Yes ☐ No
3. Is your child currently taking any medicine? ☐ Yes ☐ No
4. Is your child sensitive or allergic to anything or ever had an unfavorable reaction to any medicine? ☐ Yes ☐ No
5. Has your child ever been hospitalized? ☐ Yes ☐ No
6. Has your child ever had a thumb sucking habit? ☐ Yes ☐ No
7. Has your child had any previous orthodontic treatment? ☐ Yes ☐ No
8. Have other members of his/her family—brothers, sisters, parents—had orthodontic treatment? ☐ Yes ☐ No
9. Has there been a prominent lower jaw and "underbite" or a very short lower jaw and "overbite" in any relative on either the mother's or father's side of the family? ☐ Yes ☐ No
10. Does your child have difficulty chewing or swallowing? ☐ Yes ☐ No
11. Does your child experience noise, pain, or difficulty with movement in his/her jaws? ☐ Yes ☐ No

12. Are you planning to move from San Luis Obispo County within the next 3 years? ☐ Yes ☐ No
13. Has your child had any of the following? (Check all that apply)

- ☐ Heart trouble or congenital heart lesions
- ☐ Replacement heart valve or replacement joint
- ☐ Rheumatic Fever
- ☐ Asthma or other lung disorders
- ☐ Tuberculosis
- ☐ Skin rash or hives
- ☐ Diabetes
- ☐ Stomach disorders
- ☐ Hormone disorders
- ☐ Thyroid abnormalities
- ☐ Hepatitis or other liver disorders
- ☐ Kidney disorders
- ☐ Blood or bleeding disorders
- ☐ Anemia
- ☐ Epilepsy
- ☐ Nervousness
- ☐ Fainting or dizziness
- ☐ Other _____

DATE	History Updates