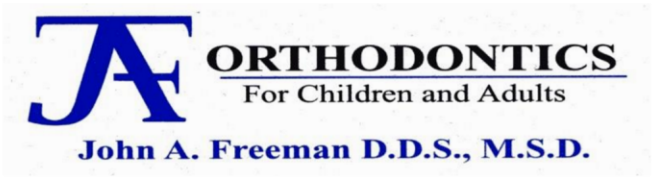

Welcome to our practice . . . please tell us about your child!

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) :	PREFERRED FIRST NAME:	BIRTHDATE:	GENDER:
STREET ADDRESS:	CITY:	ZIP:	HOME PHONE NUMBER:
WHO DOES THE PATIENT LIVE WITH? (MOM, DAD, BOTH, OTHER) :	SCHOOL PATIENT ATTENDS:		GRADE:
IN CASE OF EMERGENCY, PLEAST NOTIFY: NAME: PHONE NUMBER: RELATION:		FAVORITE HOBBIES/SPORTS? (OPTIONAL)	
HOW DID YOU HEAR ABOUT US, OR WHO MAY WE THANK FOR REFERRING YOU? ASK US ABOUT OUR REFERRAL PROGRAM!			
DENTIST'S NAME:	LAST VISIT: (approximate)	PHYSICIAN'S NAME:	LAST VISIT: (approximate)
FREQUENCY OF DENTAL CHECKUPS: (EX: ONCE OR TWICE A YEAR, ONLY IF PROBLEM, NEVER)			HOW OFTEN DO YOU FLOSS?

Responsible Parties, Custodial Parents, or Legal Guardians Information:

NAME: (LAST, FIRST, MIDDLE INITIAL)		NAME: (LAST, FIRST, MIDDLE INITIAL)	
STREET ADDRESS: (IF DIFFERENT FROM PATIENT)		STREET ADDRESS: (IF DIFFERENT FROM PATIENT)	
CITY: STATE: ZIP:		CITY: STATE: ZIP:	
CELL PHONE NUMBER:	EMAIL ADDRESS:	CELL PHONE NUMBER:	EMAIL ADDRESS:
EMPLOYER:	OCCUPATION:	EMPLOYER:	OCCUPATION:
WORK ADDRESS:	WORK PHONE NUMBER:	WORK ADDRESS:	WORK PHONE NUMBER:
CITY: STATE: ZIP:		CITY: STATE: ZIP:	
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	

Dental Insurance Information:

D.O.B. OF RESPONSIBLE PARTY:	SOCIAL SECURITY NUMBER:	D.O.B. OF RESPONSIBLE PARTY:	SOCIAL SECURITY NUMBER:
INSURANCE COMPANY NAME: GROUP #: (IF KNOWN)		INSURANCE COMPANY NAME: GROUP #: (IF KNOWN)	
INSURANCE COMPANY STREET ADDRESS:		INSURANCE COMPANY STREET ADDRESS:	
CITY: STATE: ZIP:		CITY: STATE: ZIP:	
INSURANCE COMPANY PHONE NUMBER:		INSURANCE COMPANY PHONE NUMBER:	

Health and Dental History

1. Does your child have any health problems? ◯ Yes ◯ No

2. Is your child under treatment by a physician? ◯ Yes ◯ No

3. Is your child currently taking any medication? ◯ Yes ◯ No

4. Is your child sensitive or allergic to anything, or had a bad reaction to 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 their 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 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 the jaw? ◯ Yes ◯ No

12. Are you planning to move from San Luis Obispo County in 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 or Dental Anxiety
- ◯ Fainting or dizziness
- ◯ Other_____

Doctor Notes: