SULLIVAN ORTHODONTICS
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Board Certified Orthodontist

PATIENT INFORMATION - Child

All About Your Child

Patient's name_____ Nickname _____
Last First Mi
Male _____ Female _____ Birthdate _____ Age _____ School _____ Grade _____
Hobbies/Sports _____
Child's Residence _____
Street City Zip
Child's Home phone _____ Email _____

Who Is Accompanying Your Child Today?

Name _____ Relation _____
Parents Marital Status _____ Do you have legal custody of this child_____
Whom may we thank for referring you? _____
Other family members seen by us? _____

☐ Mother ☐ Step Mother ☐ Guardian

Name _____ Employer_____
Cell # _____ Home # _____ Work # _____
Residence _____
Street City Zip
Email _____D.O.B. _____ How long at current job? _____
Title _____ Do you have dental insurance with orthodontic coverage?_____

☐ Father ☐ Step Father ☐ Guardian

Name _____ Employer_____
Cell # _____ Home # _____ Work # _____
Residence _____
Street City Zip
Email _____ D.O.B. _____ How long at current job? _____
Title _____ Do you have dental insurance with orthodontic coverage?_____

Who will be responsible for making appts?_____ Who will be responsible for the account? _____
Do you prefer email or text message reminders for upcoming appointments?: Email ☐ Text Msg ☐

DENTAL HISTORY

General Dentist _____Date of last visit_____
What are your main concerns that you would like orthodontics to accomplish?

_____

Does your child have or ever had any of the following traits?

☐ Clenching/Grinding ☐ Nail Biting ☐ Mouth Breather ☐ Soda Pop Drinker
☐ Lip Sucking/Biting ☐ Thumb/Finger Sucker ☐ Tongue Thruster ☐ Bleeding Gums

☐ Has your child ever been evaluated for orthodontic treatment?
☐ Has your child ever been informed of any missing or extra permanent teeth?
☐ Does your child brush his/her teeth daily?
☐ Floss his/her teeth daily?
☐ Has puberty begun?
☐ Has menstruation begun? (Girls)
☐ Have you ever had a serious problem with your child's previous dental work?
☐ Have you ever lost or chipped any teeth?

___ Has there ever been any injury to the: face/mouth/teeth/chin?
___ Has anyone in your family received orthodontic treatment?
How did they feel about the result?_____
___ Does your child now or have they ever experienced pain or discomfort in their jaw joint (tmj)?
___ Are you aware that some appointments will be during work/school hours?

Your child's current dental health is: ☐ Good ☐ Fair ☐ Poor

MEDICAL HISTORY

Child's Physician _____Date of Last Visit_____
Phone _____ Is your child currently under the care of a physician? _____
Your child's current medical condition is: ☐ Good ☐ Fair ☐ Poor
Please list all medications your child is currently taking _____

Please list all medications/materials your child is allergic to _____
Circle any of the medical conditions below that your child has had or currently has:

☐ Abnormal bleeding	☐ Congenital Heart Defect	☐ Handicaps/Disabilities	☐ HIV / Aids
☐ Add/Adhd	☐ Diabetes	☐ Hearing Impairment	☐ Kidney problems
☐ Anemia	☐ Difficulty Breathing	☐ Heart Murmur	☐ Migraines/headaches
☐ Arthritis	☐ Dizziness	☐ Heart Problems	☐ Nervous Disorders
☐ Artificial Bones/Joints	☐ Depression/Anxiety	☐ Hepatitis	☐ Pneumonia
☐ Asthma or Hayfever	☐ Epilepsy	☐ Herpes/Fever Blisters	☐ Radiation/Chemo/Cancer
☐ Bone Disorders	☐ GI Disorders	☐ High/Low Blood Pressure	☐ Sinus Problems

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ D.O.B. _____Insured's SS #/ID# _____

Insurance Company_____ Group No._____ Plan No. _____

Insurance Co Phone No. _____ Employer _____

Do you have dual coverage? Yes☐ No☐ If yes:

Insured's Name_____ D.O.B_____ Insured's SS #/ID# _____

Insurance Company_____ Group No._____ Plan No. _____

Insurance Co Phone No. _____ Employer _____

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. *In addition, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

Signature: _____Date: _____