CHILD ORTHODONTIC ACQUAINTANCE QUESTIONNAIRE

Patient's Name _____ Name Preferred _____ Male___ Female____

Primary Tele# _____ ☐Home ☐Cell ☐Other Birthdate _____ Patient's Age _____

Address _____ City _____ State ____ Zip _____

E-mail Address _____ School _____

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

FATHER _____ MOTHER _____

Employer _____ Employer _____

Position _____ Position _____

Tele# _____ ☐Work ☐Cell Tele# _____ ☐Work ☐Cell

Financially Responsible Party

Name_____(male / female) Relationship_____

Address_____ City_____ State_____ Zip_____

Phone#_____(cell / home / office) Date of Birth_____

Driver's Lic#_____ Social Security#_____

Are you here for orthodontic treatment (braces/Invisalign)? . . . . . Yes No

Ever consulted an **orthodontist**? . . . . . Yes No

Has patient ever been treated by an **orthodontist**? . . . . . Yes No

Who is your dentist? _____ When was the patients last dental cleaning? _____

Do you plan on relocating in the next 2-3 years? _____ How did you hear about us? _____

Other children in the household & their ages? _____

Have your other children been treated here or examined here? . . . . . Yes No

If "YES", who? _____

Any problem with the patient's health now? . . . . . Yes No

Please place an "X" if the patient **has now or has ever** had the following:

____ Heart defect, trouble, abnormality
____ Sensitive Gag Reflex
____ Latex Allergy
____ Nickel Allergy
____ Excessive bleeding
____ Hepatitis or liver problems
____ Convulsions or seizures
____ Fainting spells
____ Nervous, emotional problems or hyperactivity
____ Now taking medication
____ Gum disease
____ Mouthbreathing or noisy sleeping
____ Shoulder or neck pains
____ Speech abnormality or lisp
____ Soreness in jaws or teeth
____ Popping or noises in jaw joints
____ Ringing or buzzing noise
____ Difficulty opening or closing
____ Locking jaws open or closed
____ Frequent earaches
____ Frequent headaches
____ Frequent ear infections
____ Thumb or finger sucking: active / previous (circle)
____ Tongue thrusting
____ Asthma
____ Nasal allergies or hay fever

Is patient being treated by a physician? . . . . . Yes No

The information above is correct and the insurance information is complete.

Parent's Signature_____ Date _____

Parent's Signature_____ Date _____

INSURANCE INFORMATION

Please fill out information for each dental plan that the patient is covered under.

1. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____

2. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____

3. Dental Insurance Company _____
   Toll Free Phone # _____
   Subscriber's Name_____Relation to Patient_____
   Subscriber's Social Security #_____
   Subscriber's Date of Birth _____
   Employer _____
   Plan # _____
   Group #_____
   Claim's Address _____
   _____
   _____