

Date: _____

PATIENT INFORMATION - CHILD

Child's Full Legal Name: _____ Gender: _____

Nickname: _____ Hobbies: _____

Date of Birth: _____ Age: _____

Home Phone: _____ Which school does your child attend? _____

Does the patient have any siblings? ____ If yes, what are their ages? _____

Home Mailing Address: _____

Parents' Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ____ Partnered ____ Widowed

RESPONSIBLE PARTY INFORMATION - REQUIRED

Father's name: _____ Date of Birth: _____

Address: _____ Cell Phone: _____
(Address if different from above)

Email: _____

Do you own or rent your home? _____ For how long? _____

Occupation: _____ Employed by: _____

Length of employment: _____ Business Phone: _____

Mother's name: _____ Date of Birth: _____

Address: _____ Cell Phone: _____
(Address if different from above)

Email: _____

Do you own or rent your home? _____ For how long? _____

Occupation: _____ Employed by: _____

Length of employment: _____ Business Phone: _____

GENERAL INFORMATION

Whom should we thank for referring you to our office? _____

Have you visited our Website? ____ Do you use Facebook, Google Reviews, or Yelp Reviews? (circle all that apply)

Which search engine do you prefer to use (Google, Bing, Explorer, Yahoo)? _____

Has anyone else in your family had orthodontic treatment? _____

Does your child have any special needs or sensory issues? _____

DENTAL INSURANCE INFORMATION

Name of policy holder: _____ Policy holder's SS#: _____

Policy holder's date of birth: _____ Insurance Company Name: _____

Insurance Company Address: _____

Employer Name: _____ Insurance Phone #: _____

Policy holder ID#: _____ Group #: _____

PATIENT MEDICAL HISTORY

Current Primary Care Dentist: _____ Don't have one I don't remember

Last dental appointment: Less than 6 months ago 6-12 months ago More than 12 months ago

Is the patient pregnant? Unsure No Yes Is the patient under the care of a physician? No Yes

Are you taking any medications? _____

Is the patient currently taking or has ever taken a bisphosphonate? Or any medication to make bones stronger, such as: Actonel, Aredia, Boniva, Fosamax, Didronel, Skelid, Zometa, other: _____

For **orthodontic treatment**, please let us know if the patient has (check all that apply):

- Been evaluated for orthodontic treatment before Had the tonsils or adenoids removed
 Ever received an injury to the face, mouth, teeth or chin Difficulty breathing
 Had any pain or clicking sounds in the jaw joint (TMJ) Ever broken a tooth
 Been told to take an antibiotic prior to dental visits Had problems with previous dental work

Does the patient have any of the following **medical conditions**?

NO MEDICAL CONDITIONS

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal bleed | <input type="checkbox"/> Cancer | <input type="checkbox"/> Endocrine/growth disorders | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Abnormal breathing | <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Handicaps/disabilities | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Artificial bones/joints | <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney/liver problems |
| <input type="checkbox"/> Autism/Asperger's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia/blood disorders | <input type="checkbox"/> Lupus |

Allergies (check all that apply): **NO ALLERGIES** Antibiotics Aspirin Codeine
 Dental Anesthetics Latex Metal Plastic

Please list any other allergies: _____

Please describe any serious medical problems the patient has experienced: _____

Has the patient ever had any of the following habits (check all that apply)?

- Clenching/Grinding Teeth Mouth Breathing Nail Biting Lip Sucking Thumb Sucking Difficulties with Speech
 Tobacco Use Tongue Thrust Snoring Chews on Ice / Pens / Pencils / Water Bottles **None of the Above**

Dental Hygiene (check all that apply): Brush twice a day Floss regularly Gums Bleed Taking Fluoride Supplements

Please list any other dental concerns that may be helpful: _____

CONFIRM

I confirm that the information I have provided about the patient or myself is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in medical status that occur after this date. I authorize Dr. Garcia and his team to perform an initial orthodontic examination and any necessary dental services that I or the patient may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

(You will sign this at your appointment)

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Join Dr. García's Kids' Club

About our Kids' Club.....

- Dr. Garcia is trained to spot subtle problems with jaw growth and emerging teeth while some baby teeth are still present.
- As a preventative orthodontic office, Dr. Garcia likes to examine children by age 7 to track growth patterns.
- Usually, no orthodontic treatment will be needed at this time and with that good news, Dr. Garcia will place your child in our program where he will continue to monitor their growth and development at no charge. This service is completely complimentary.
- If your child has not yet reached their 7th birthday, we will keep their name in our system and when their 7th birthday approaches, we will contact you regarding setting up their complimentary evaluation.

List any family member you would like to receive an initial examination at age 7.	
Name	Date of Birth
Additional family member over the age of 7 you would like to receive a complimentary examination in the near future.	
Name	Date of Birth

Welcome to our orthodontic family. It is our honor and privilege to provide you with the finest orthodontic care while creating your beautiful new smile!

Sincerely,

Dr. Garcia