The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Charles B. McDermott DDS, MS ORTHODONTICS

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: ___/___/___ ❑ Male ❑ Female

Child's Name: _____
LAST FIRST MI

Nickname: _____ SS#: _____

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

2 Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

3 Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Home #: (___) _____

Wk #: _____ Ext: ___ Cell #: (___) _____

Birthdate: ___/___/___ Age: ___ SS#: _____

Address: _____
APT/CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

4 Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Home #: (___) _____

Wk #: _____ Ext: ___ Cell #: (___) _____

Birthdate: ___/___/___ Age: ___ SS#: _____

Address: _____
APT/CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group #: (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group #: (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ___/___/___ SS#: _____

Policy Owner's Employer: _____

6

How did you hear about our office?

❑ Dentist ❑ Friend ❑ Yellow Pages ❑ Newspaper

_____

_____

_____

7

What are the main concerns that you would like orthodontics to address?

_____

_____

_____

_____

_____

_____

continued on back

8 Dental History

Has your child ever been evaluated for or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain / discomfort in his/her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking:

_____

_____

_____

_____

9 Allergies

Is your child allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metals/Plastics	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to: _____

_____

_____

_____

10 Medical History

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding/Hemophilia	Y N Diabetes
Y N Allergies to any Drugs	Y N Handicaps / Disabilities
Y N Allergy to Latex / Metals	Y N Hearing Impairment
Y N Allergy to Plastic	Y N Heart Murmur
Y N Any Hospital Stays	Y N Hemophilia
Y N Any Operations	Y N Hepatitis
Y N Asthma	Y N HIV + / AIDS
Y N Cancer	Y N Kidney / Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic / Scarlet Fever
Y N Convulsions / Epilepsy	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had: _____

_____

_____

_____

_____

_____

11 Habits

Does / Did Your Child Have Any of the Following Habits?

Y N Clenching / Grinding Teeth	Y N Speech Problems
Y N Lip Sucking / Biting	Y N Thumb / Finger Sucking
Y N Mouth Breather	Y N Tongue Thrust

12

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature Date

Doctor's Comments:

Initials:_____ Date:_____

_____

_____

_____

_____

_____

_____

_____