

### CHILD INFORMATION

Today's Date: \_\_\_\_\_ Nickname: \_\_\_\_\_

Child's Name: \_\_\_\_\_

LAST

FIRST

MIDDLE

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_

CITY STATE ZIP CODE

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/ Sports: \_\_\_\_\_

Other Siblings/ ages: \_\_\_\_\_

### Orthodontic Insurance

Orthodontic Coverage Y N

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#/ ID#: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

### PARENT'S INFORMATION

Person responsible for the account: \_\_\_\_\_ Relation: \_\_\_\_\_

Parent's Marital Status:  Single  Married  Partnered  Widowed  Separated  Divorced

Relation to Patient:  Mother  Step Mother  Guardian

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_ Number of years with current employer? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is the best method for us to contact you? Cell Home Work Email

Relation to Patient:  Father  Step Father  Guardian

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_ Number of years with current employer? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is the best method for us to contact you? Cell Home Work Email

### Dental Information

General Dentist: \_\_\_\_\_

Date of last cleaning/ visit: \_\_\_\_\_

How did you hear about us?  
(Check all that apply)

- Dentist
- Family Member/ Friend
- Website
- Google
- Social Media
- School: \_\_\_\_\_
- Other (Please Specify): \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

## Dental History

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

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Had or been evaluated for orthodontic treatment?	Y	N
Had a serious/difficult problem associated with any previous dental work?	Y	N
Had any injuries to the face, mouth, teeth or chin? When? Explain? _____	Y	N
Do you now, or have you experienced pain/discomfort in your jaw joint (TMJ/ TMD)?	Y	N
Do you like your smile?	Y	N
Gums ever bleed?	Y	N
Do you see a general dentist regularly?	Y	N
Have speech problems?	Y	N
Had tonsils or adenoids removed?	Y	N
Do you have any missing or extra permanent teeth?	Y	N
Do you brush your teeth daily?	Y	N
Floss daily?	Y	N
Ever taken Phen-Fen (Redux, Pondimin)?	Y	N
Ever taken Fosamax, or any other bisphosphonate?	Y	N
Are you aware that some appointments may/will infringe upon work or school time?	Y	N
Do you smoke or use tobacco in any form?	Y	N

### ALLERGIES/ PRE-MED ( CHECK ALL THAT APPLY)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Nickel/ Metals	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Latex	<input type="checkbox"/> Other: _____
Do you require pre-medication before any dental procedure?	Y	N

### Have you ever experienced any of the following?

Clenching/ Grinding Teeth	Y	N
Nursing Bottle Habits	Y	N
Lip Sucking/ Biting	Y	N
Speech Problems	Y	N
Mouth Breather	Y	N
Thumb/ Finger Sucking	Y	N
Nail Biting	Y	N
Tongue Thrust	Y	N
Used Pacifier until age _____	Y	N

**By signing below, patient/ responsible party acknowledges the information filled out on this form is accurate and agrees to notify Garcia Family Orthodontics/ Ana V. Garcia, DDS PA of any changes that occur. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y	N
ADD/ ADHD	Y	N
Anemia	Y	N
Any hospital stays When? _____	Y	N
Any Operations When? What? _____	Y	N
Artificial Bones/Joints/Valves	Y	N
Arthritis	Y	N
Asthma	Y	N
Blood Transfusion	Y	N
Cancer/Chemotherapy	Y	N
Chicken Pox	Y	N
Congenital Heart Defect	Y	N
Convulsions/Epilepsy/ Seizures	Y	N
Currently Pregnant	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Diphtheria	Y	N
Drug/ Alcohol Abuse	Y	N
Emphysema	Y	N
Endocrine/ Thyroid Problems	Y	N
Fever Blisters	Y	N
Glaucoma	Y	N
Handicaps/ Disabilities Specify: _____	Y	N
Hearing Impairment	Y	N
Heart Attack/ Stroke	Y	N
Heart Murmur	Y	N
Heart Problems	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
Herpes	Y	N
High/ Low Blood Pressure	Y	N
HIV +/- AIDS	Y	N
Kidney/ Liver Problems	Y	N
Lupus	Y	N
Measles	Y	N
Mitral Valve Prolapse	Y	N
Mumps	Y	N
Polio	Y	N
Psychiatric Problems	Y	N
Radiation Treatment	Y	N
Rheumatic/ Scarlet Fever	Y	N
Severe/ Frequent Headaches	Y	N
Shingles	Y	N
Sickle Cell Disease/ Traits	Y	N
Sinus Problems	Y	N
Tuberculosis (TB)	Y	N
Ulcer/ Colitis	Y	N
Venereal Disease	Y	N

List any other serious medical

condition(s) that apply or any medications being taken:

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