NEW PATIENT ORTHODONTIC ACQUAINTANCE FORM - CHILD

Date:______/______/_________ **How did you hear about us?:**____
Reason for Consultation (Primary Concerns):____

PATIENT INFORMATION

Patient's Full Name (Last): _________________________________(First):________________________________
Date of Birth: Month:_____________ Day______ Year___________
Email Address:____________________________ **Phone:** (____)______-_______ Alt Phone:(____)______-______
Home Address: ________________________________ Apt: _____City: ________________ State_____Zip_______

DENTAL & MEDICAL CONTACT INFORMATION

General Dentist Name: ___________________________**Practice Name:** ________________________________
Phone:(______) _______-__________ City: ___________________________

Physician:__________________________ **Practice (Hospital) Name:** ___________________________________
Phone:(______)_______-__________ City: ____________________________

FATHER'S INFORMATION

Full Name:____ Phone:(______)_______-___________
Email Address:_____________________________________ Business Phone:(______)______-_________
Occupation:_________________________________ Employed By:________________________________

MOTHER'S INFORMATION

Full Name:____ Phone:(______)_______-___________
Email Address:____________________________________ Business Phone:(______)______-_________
Occupation:_________________________________ Employed By:_______________________________

INSURANCE INFORMATION

Primary Insurance Information
Policy Holder Name:_________________________________Policy Holder Date of Birth: ______________________
Employer Name:__________________________Insurance Company Name:________________________________
Insurance Phone #:*(_____)*_____-________Group Number:___________________Subscriber ID:________________

Secondary Insurance (if applicable):*only your primary insurance benefits will be reflected on your contract; if desired we can prepare the paperwork for you to submit claims to your secondary insurance for you to collect directly from your secondary ins.*
Policy Holder Name:_________________________________Policy Holder Date of Birth: ______________________
Employer Name: ________________________Insurance Company Name:________________________________
Insurance Phone #:*(_____)*_____-________Group Number:____________________Subscriber ID:______________

CHILD MEDICAL HISTORY

Please answer Y (yes) or N (no)

Y/N Is the patient in good health?
Y/N Do the patient have any history of major illness? Please explain:
Y/N Haas the patient ever been under the care of a physician for illness?
Y/N Has the patient ever been hospitalized? Please explain:
Date of last examination by physician:_________
Y/N Does the patient bruise easily
Y/N Has the patient ever required a blood transfusion?
Y/N Does the patient have a tendency to colds?
Y/N Does the patient have a tendency for sore throats?
Y/N Has the patient had his/her tonsils removed?
If yes at what age?_______
Y/N Does the patient have chronic ear pain or infections?
Y/N Does the patient have trouble sleeping?
List any drugs or medications the patient is currently taking:_________________________

Please indicate Y (yes) or N (no) to any condition below you have experienced:

Y/N Heart murmur
Y/N Rheumatic Fever
Y/N High blood pressure
Y/N Low blood pressure
Y/N Hepatitis
Y/N Diabetes
Y/N Kidney disease
Y/N Epilepsy
Y/N Fainting
Y/N Arthritis
Y/N Asthma
Y/N Pneumonia
Y/N Nervous or anxious
Y/N Cancer treatment
Y/N Tumors or growths
Y/N Thyroid/parathyroid problems
Y/N Bone disorders
Y/N Seizures
Y/N Endocrine problems
Y/N Frequent headaches
Y/N Immune system problems
Y/N Psychiatric care
Y/N Prolonged bleeding
Y/N Anemia/blood pressure
Y/N Tuberculosis
Y/N Often fatigued/exhausted
Y/N Recent weight gain/loss
Y/N Sinus trouble

Are you allergic or have reacted adversely to:

Y/N Local anesthetics
Y/N Penicillin/other antibiotics
Y/N Sulfa drugs
Y/N Barbiturates, sedatives or sleeping pills
Y/N Aspirin
Y/N Iodine
Y/N Codeine or other narcotics
Other:____

DENTAL HISTORY (Date of your last dental examination or treatment__________________)

Y/N Has the patient had any serious problems associated with prev. dental tx? Please explain:______________________
Y/N Has the patient had any injuries to face, mouth, or teeth? Please explain:___________________________________
Y/N Has there been any treatment for problems of jaw joint or for facial muscle spasms? Please explain:______________
Y/N Has patient ever sucked your thumb or fingers?
Until what age?________
Y/N Does patient have speech problems?
Y/N Is patient a mouth breather? At what times?___________
Y/N Has patient been informed of any missing or extra teeth?
Y/N Does patient use a mouth guard or splint?
Y/N Does patient clench or grind teeth?
Y/N Clicking, popping or grating from patient's jaw?
Y/N Numbness/tingling w/ patient's face/mouth?
Y/N Has patient had any prev.orthodontic treatment?
Y/N Has an orthodontist been consulted previously?
Y/N Has patient ever had periodontal (gum) disease?
Y/N Has either parent had orthodontics treatment?
Y/N Has either parent had periodontal disease?

Print Full Name:____

Signature:____ **Date:**_______________________

By signing above you attest that the above is correct & is only intended for use in the office of Dr. Jesse Ko & Dr. Anne Yoon