



# HOWELL ORTHODONTICS

## Tell Us About Your Child

Today's Date: \_\_\_/\_\_\_/\_\_\_ Preferred Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST MI

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

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

CITY STATE ZIP

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

School: \_\_\_\_\_ Hobbies: \_\_\_\_\_

## General Information

Who is accompanying child today?  
\_\_\_\_\_

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?  
\_\_\_\_\_

Other siblings/ages: \_\_\_\_\_

Preferred appointment reminder method:

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

Text #: \_\_\_\_\_

## Parents' Information

Father  Stepfather  Guardian

Mother  Stepmother  Guardian

Marital Status: S M D W Birthdate: \_\_\_/\_\_\_/\_\_\_

Marital Status: S M D W Birthdate: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: (If different than child's)  
\_\_\_\_\_  
\_\_\_\_\_

Address: (If different than child's)  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

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

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

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

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

### DENTAL INSURANCE

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

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

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_

(PLEASE COMPLETE BACK OF FORM)

# Dental and Medical History

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

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

Last cleaning: \_\_\_/\_\_\_/\_\_\_ Has patient ever been evaluated for or had orthodontic treatment?: Y / N

Child's Interest in treatment:  Excited  Willing  Reluctant

Does/did the patient have the following habits? Grind Teeth Y / N Finger/Thumb Sucking Y / N

Have  Tonsils  Adenoids been removed?  No

Has the patient experienced any unfavorable reaction from any previous dental or medical care? Y / N

Does patient require antibiotics before dental procedures? Y / N

If yes, please specify and provide a reason for this need: \_\_\_\_\_

Does the patient brush teeth:  Often  Occasionally  Reluctantly

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Is patient currently under a physician's care? Y / N If yes, explain: \_\_\_\_\_

Is patient taking any medicine at this time? Y / N Please specify: \_\_\_\_\_

Is patient allergic to any medications? Y / N Please specify: \_\_\_\_\_

Does patient have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify: \_\_\_\_\_

Has the patient been hospitalized or had any surgeries?? Y / N Please specify: \_\_\_\_\_

Does the patient have any history of these ?:

Yes / No Seasonal Allergies	Yes / No Lung Disorder	Yes / No Heart Disorder/Murmur	Yes / No Speech Difficulties
Yes / No Anemia	Yes / No Breathing Difficulties	Yes / No Hypertension	Yes / No Emotional Disorders
Yes / No Prolonged bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Congenital Heart Disease	Yes / No Hearing Difficulties
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Rheumatic Fever	
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Endocrine/Hormone Disorders	
Yes / No Artificial Joint	Yes / No Neurologic Disorder	Yes / No Diabetes	
Yes / No AIDS or HIV	Yes / No Cerebral Palsy	Yes / No Hepatitis or Liver Disorder	_____
Yes / No ADD/ADHD	Yes / No Convulsions/Seizures	Yes / No Kidney or Bladder Disorder	<b>Doctor's Initials</b>

If patient is experiencing or has a history of any disease, condition or problem not addressed, please explain:

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

Relationship to patient: \_\_\_\_\_