FOOTHILL ORTHODONTICS
Child Patient Data

Date _____

Name _____
First Initial Last Nickname DOB Age Sex

Address_____ City_____ Zip_____

Home Phone_____ Parent Cell_____

Dentist_____ Physician_____ School_____ Grade_____

Whom may we thank for referring you to us?_____

Father's Name_____ Home Phone_____

Address_____ City_____ Zip_____

Occupation_____ Employer_____ How Long_____ Work #_____

Mother's Name_____ Home Phone_____

Address_____ City_____ Zip_____

Occupation_____ Employer_____ How Long_____ Work #_____

Parent Marital Status_____ Other Children_____

Have we treated or evaluated other family members?_____

Have you undergone orthodontic treatment elsewhere?_____

Dental Insurance Data

Father's Insurance Co._____ PPO/HMO/Premiere_____

Father's SS#_____ DOB_____ Ins Phone_____

_____ Cov Amt_____ Mo/Qtr/SAnnual_____
Group Name Group #

Mother's Insurance Co._____ PPO/HMO/Premiere_____

Mother's SS#_____ DOB_____ Ins Phone_____

_____ Cov Amt_____ Mo/Qtr/SAnnual_____

Medical and Dental History

Is your child in good health?_____ Yes No

Date of last physical exam_____ Date of last dental check-up_____

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

If so, for what reason?_____

Is your child taking any drugs or medications, please list_____

Is your child sensitive or allergic to any drugs, latex or metals?_____ Yes No

If so, please list_____

Does your child have or has your child had any of the following:

____Anemia	____Cold Sores	____Drug Addiction	____Respiratory Disease
____Allergies	____Asthma	____Kidney Disease	____High Blood Pressure
____AIDS	____Strep	____Mental Disorder	____Epilepsy or Seizures
____Diabetes	____Hay Fever	____Rheumatic Fever	____Excessive Bleeding
____Arthritis	____Head Injury	____Thyroid Disease	____Fainting or Dizziness
____Liver Disease	____Scarlet Fever	____Blood Transfusion	____Radiation Treatment
____ Sinus Infection	____Blood Disease	____Venereal Disease	____Jaw Joint Problems

If there is another condition, please describe_____

Have you been informed of any missing or extra teeth?_____ Yes No

Has your child had any unpleasant experiences at a dental office?_____ Yes No

Have you consulted another orthodontist?_____ If so, who?_____

What is your primary reason for coming to our office?_____

What would you like for us to do for your child?_____

In your opinion, what is your child's attitude towards braces?_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist and his staff to determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the orthodontist and his staff.

I further acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES.

Signature_____ Date_____

I authorize_____ to act on my behalf during the initial evaluation.

Signature_____ Relationship to Patient_____ Date_____