



502-426-2744

CHILD PATIENT QUESTIONNAIRE

Today's Date _____

FULL NAME _____ NICK NAME _____

DATE OF BIRTH _____ AGE ____ Years ____ Months

SEX () M () F

ADDRESS: Street _____

City _____ State _____ Zip _____

TELEPHONE: Residence () _____ Business () _____ Cell () _____

E-MAIL ADDRESS _____

SCHOOL ATTENDING _____ GRADE _____

PERSON RESPONSIBLE FOR FINANCIAL MATTERS:

Name _____ Relationship to Patient: _____

Address: Street _____

City _____ State _____ Zip _____

TELEPHONE: Residence () _____ Business () _____ Cell () _____

PRIMARY ORTHODONTIC INSURANCE (DENTAL)

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 Dental Insurance (DENTAL)

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 Birthdate __/__/__ SS# ___-___-_____ Policy Owner's Employer _____

1. FAMILY STATUS

Mother's Information: Mother___ Step-Mother___ Guardian___

Name _____ Birth Date _____ Home # () _____

Employer Name _____ Work # () _____ ext. ___

E-mail Address _____ Cell # () _____

Father's Information: Father ___ Step-Father ___ Guardian ___

Name _____ Birth Date _____ Home # () _____

Employer Name _____ Work # () _____ ext. ___

E-mail Address _____ Cell # () _____

2. MEDICAL HISTORY

Family Physician _____ Phone # () _____

Address _____

Has Patient Ever Had:

() AIDS () Allergy () Diabetes () Hepatitis

() Lung Disease

() Anemia () Bleeding () Epilepsy/Seizures () Injury to Face

() Oral Ulcers

() Arthritis () Cerebral Palsy () Hearing Problem () Kidney Disease

() Previous Surgery

() Asthma () Cold Sores () Heart Condition () Latex Allergy

() Rheumatoid Fever

Specify: _____

Other Illness: _____

Is the patient receiving any medication? () Yes () No

Is the patient allergic to any medication? () Yes () No

Is the patient allergic to anything else? () Yes () No

Specify: _____

Does the patient need to be pre medicated (antibiotics) for routine dental procedures?

() Yes () No

If yes, specify and give reason for use: _____

Have the patient's tonsils and/or adenoids been removed? () Yes () No If yes, at what age? ____

Has the patient had any other operations? () Yes () No

If yes, specify: _____

3. DENTAL HISTORY

Family Dentist _____ Phone # () _____

Address _____

Date of last dental examination _____

Injuries or trauma to the teeth or gums? () Yes () No

If yes, specify: _____

How often does the patient brush his/her teeth?

() Several times a day () Once or twice a day () Occasionally () Never

Has the patient ever had:

Unfavorable dental experiences? () Yes () No

Specify: _____

Speech therapy? () Yes () No

Does or did the patient:

Grind his/her teeth at night? () Yes () No

Bite his/her fingernails? () Yes () No

Suck thumb, finger, pacifier, etc.? () Yes () No

If yes, at what age did he/ she discontinue? _____

Does the patient's home water supply have fluoride? () Yes () No

4. PATIENT'S TREATMENT ATTITUDE

Is the patient aware of an orthodontic problem? () Yes () No

Orthodontic consultation was prompted by _____

The patient's interest in orthodontic treatment is:

() Wants treatment () Willing if treatment is necessary () Unwilling

5. OTHER

Describe the main reason why you are, or your child is, seeking orthodontic treatment:

Whom may we thank for referring you to our office? _____

Signature of individual completing this form _____

Relationship to patient _____ Today's Date: _____