WELCOME TO MARCY ORTHODONTICS

(All information will be kept in strict confidence)

Child Acquaintance and Medical History Form

PATIENT INFORMATION

Name: _____ Gender: M/F D.O.B: _____ /____ /____
Last First Initial YYYY/ MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

School: _____ Grade: _____

FAMILY INFORMATION

Mother's Name: _____
Last First Initial

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married ☐ Other

Home Address: _____ Home Phone: _____
Street City Postal Code

Employer: _____ Position: _____

Work Phone: _____ Cell Phone: _____ Email: _____

How do you prefer to be contacted? (circle all that apply) Home Work Cell Email

Father's Name: _____
Last First Initial

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married ☐ Other

Home Address: _____ Home Phone: _____
Street City Postal Code

Employer: _____ Position: _____

Work Phone: _____ Cell Phone: _____ Email: _____

How do you prefer to be contacted? (circle all that apply) Home Work Cell Email

Person(s) responsible for payments on account: ☐ Mother ☐ Father ☐ Other
Name of Other Party: _____

Name and age of Siblings (of patient): _____

Medical History

Patient's Family Physician: _____ Phone: _____

Yes	No	
☐	☐	Is your child under a physician's care at present? Describe: _____
☐	☐	Is your child being treated for any medical conditions? Describe: _____
☐	☐	Is your child currently taking any prescription or non-prescription medications? _____

☐ ☐ Is your child allergic to any medications (e.g. Penicillin, sulfa drugs, pain relievers)? or Latex?_____
☐ ☐ Has your child ever had any serious illness? Describe: _____
☐ ☐ Has your child ever been hospitalized or undergone any type of surgery? Describe: _____
☐ ☐ Has your child ever had prolonged bleeding following a tooth extraction or minor injury? _____
☐ ☐ Are there any conditions or diseases that run in your family (e.g. diabetes, heart disease, cancer)? _____
☐ ☐ Does your child smoke or use any other tobacco products? If yes, how much? _____
☐ ☐ For females: is your child pregnant, or suspect that they may be?

Does your child have or ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Persistent Headaches/Migraines
☐	☐	Heart Murmur	☐	☐	Thyroid Disease	☐	☐	Nerve or Brain Disease
☐	☐	Heart Valve Disease	☐	☐	Liver Disease	☐	☐	Seizures/ Epilepsy
☐	☐	Heart Attack / Stroke	☐	☐	Asthma	☐	☐	Autism
☐	☐	Prosthetic Joint / Valve	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis
☐	☐	High/ Low Blood Pressure	☐	☐	Cancer/ Radiation therapy	☐	☐	Bone Disorders
☐	☐	Blood Disorder	☐	☐	Diabetes	☐	☐	Vision or Hearing Problems
☐	☐	Infectious Disease	☐	☐	Stomach Ulcers	☐	☐	Sleep Apnea
☐	☐	HIV/ AIDS	☐	☐	Herpes (any type)	☐	☐	Sinus Problems
☐	☐	Hepatitis	☐	☐	Skin disease (e.g. Eczema)	☐	☐	Allergies
						☐	☐	Other _____

Please list any other significant information about your child's medical history: _____
_____

Genetics and the pubertal growth spurt play an important role in the timing of orthodontic treatment. Can you please provide us with the following information (if the child is under 16 years of age):
I resemble my: ☐ Mother ☐ Father ☐Both ☐None
Boys: Has puberty been reached? ☐ Yes ☐ No
Girls: Has menstruation begun? ☐ Yes ☐ No

Dental History

What is your primary concern about your child's teeth and smile? _____
_____

Patient's Dentist: _____ Date of last Exam: _____

Yes No
☐ ☐ Is your child currently experiencing any dental pain? _____
☐ ☐ Has your child had any permanent teeth removed, including wisdom teeth? How many? _____
☐ ☐ Has your child ever had previous orthodontic treatment or exam? If yes, when? _____
Doctor? _____
☐ ☐ Any injuries to the face, teeth, or mouth? Describe: _____
☐ ☐ Is there currently or any history of soreness, tightness or pain in the muscles around the jaws and face?
☐ ☐ Is there currently or any history of pain in your child's jaw joints? If yes, when? _____
☐ ☐ Is there currently or any history of difficulty in your child opening or closing their jaws?
☐ ☐ Has your child's jaws ever been "locked" open or closed?
☐ ☐ Does your child clench or grind their teeth?
☐ ☐ Do you find that your child breathes predominantly through the mouth, or with their mouth open?
☐ ☐ Has your child ever sucked their thumb or finger? If yes, until what age?_____
☐ ☐ Does your child want orthodontic treatment?

Any other information you can give us is definitely appreciated. The more we know about each person, the more help we can give in managing the orthodontic treatment, both at home and in the office.
_____
_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my child's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____
Signature of parent or guardian Date

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

Insurance Information:

Our office bills the Patient or Responsible Party directly for all services rendered. We will complete the necessary forms for your submission to receive the amount of orthodontic coverage to which you are entitled.

Do you have orthodontic coverage?

☐ Yes ☐ No ☐ Dual ☐ Unsure

1. Subscribers Name: _____
   Insurance Company: _____
   Employer: _____
   Policy/Contract #: _____
   I.D./Certificate #: _____

2. Subscribers Name: _____
   Insurance Company: _____
   Employer: _____
   Policy/Contract #: _____
   I.D./Certificate #: _____