Patient Information - Child

PATIENT NAME:
Date of Birth: Age:
Address: ,
Primary Telephone:

Gender: ❒ Male ❒ Female Nickname: ______

Patient's Dentist: ______ City: ______

Please list any siblings and ages: ______

Please list any interests, sports, or hobbies: ______

Whom may we thank for referring you to our office?: ______

How did you hear about us?: ❒ Dentist ❒ Family ❒ Friend ❒ Internet Search ❒ Print Ad ❒ Yellow Pages ❒ Other ______

Mother's Information

❒ Guardian ❒ Step Mother
Name: ______
❒ Dr. ❒ Mrs. ❒ Ms.

Address: ______
Same as Patient's ❒

Hm #: ______ Cell #: ______

Work#: ______
Preferred phone: ❒ Home ❒ Mobile ❒ Work

E-mail Address: ______

Employer: ______ Job Title: ______

Father's Information

❒ Guardian ❒ Step Father
Name: ______
❒ Dr. ❒ Mr.

Address: ______
Same as Patient's ❒

Hm #: ______ Cell #: ______

Work#: ______
Preferred phone: ❒ Home ❒ Mobile ❒ Work

E-mail Address: ______

Employer: ______ Job Title: ______

KUHLBERG ORTHODONTICS

Primary Dental Insurance

Do you have orthodontic coverage? ❒ Yes ❒ No
Insurance Co. Name: ______

Member ID: ______ Group #: ______

Member Name: ______

SS#: ______ D.O.B.: ______

Secondary Dental Insurance

Do you have orthodontic coverage? ❒ Yes ❒ No
Insurance Co. Name: ______

Member ID: ______ Group #: ______

Member Name: ______

SS#: ______ D.O.B.: ______

Marital Status: ❒ Married ❒ Single ❒ Separated ❒ Divorced ❒ Partnered ❒ Widowed

Who is accompanying your child today?: ______ Do you have legal custody of this child?: ❒ Yes ❒ No

Who is responsible for making appointments?: ______

If the office accepts this insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Parent or Guardian's Signature ______ *Date* ______

**Please make any necessary corrections to autofilled information*

Please See Reverse

PATIENT NAME:
Date of Birth:
PARENT/GUARDIAN:
Address:
,
Primary Telephone:

Please make any changes or corrections here:

***** What are your main orthodontic concerns?

____

____

Child Confidential Medical and Dental History

Has your child ever had any of the following conditions?

Condition		Condition	
Abnormal bleeding	❒ Yes ❒ No	Endocrine/Growth disorders	❒ Yes ❒ No
Attention Deficit Disorder/ADHD	❒ Yes ❒ No	Handicaps/Disabilities	❒ Yes ❒ No
Allergies to any drugs	❒ Yes ❒ No	Heart murmur	❒ Yes ❒ No
Allergy to Latex	❒ Yes ❒ No	Hemophilia/Blood disorders	❒ Yes ❒ No
Any hospital stays	❒ Yes ❒ No	Hepatitis	❒ Yes ❒ No
Any operations/surgery	❒ Yes ❒ No	HIV/AIDS	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Kidney/Liver Problems	❒ Yes ❒ No
Cancer	❒ Yes ❒ No	Nickel Allergy	❒ Yes ❒ No
Chronic Sinus Problems	❒ Yes ❒ No	Rheumatic/Scarlet Fever	❒ Yes ❒ No
Congential heart defect	❒ Yes ❒ No	Tonsils/Adenoids Removed	❒ Yes ❒ No
Convulsions/Epilepsy	❒ Yes ❒ No	Tuberculosis	❒ Yes ❒ No
Diabetes	❒ Yes ❒ No	Other Medical or Health Conditions not listed	*DESCRIBE BELOW*

Is your child currently under the care of a physician for any medical problems? ❒ Yes ❒ No

PLEASE DESCRIBE ANY "YES" ANSWERS: ____

____

Are your child's vaccines up-to-date? ❒ Yes ❒ No   Has your child had chicken pox? ❒ Yes ❒ No ❒ Vaccine
Has your child ever been told to take an antibiotic medication prior to dental vists? ❒ Yes ❒ No
Please list any drugs/medications that your child is taking: ____

KUHLBERG ORTHODONTICS

____

Does your child have any of the following habits?

Habit		Habit	
Clenching or grinding teeth	❒ Yes ❒ No	Nursing bottle habit	❒ Yes ❒ No
Lip sucking or biting	❒ Yes ❒ No	Speech problems or receiving speech therapy	❒ Yes ❒ No
Mouth breathing/snoring	❒ Yes ❒ No	Thumb or finger sucking	❒ Yes ❒ No
Nail biting	❒ Yes ❒ No	Tongue thrust	❒ Yes ❒ No

Has your child ever been evaluated or had orthodontic treatment before? ❒ Yes ❒ No
Has your child ever received an injury to the face, mouth, jaws, teeth, or chin? ❒ Yes ❒ No
Have you been informed about any missing or extra permanent teeth? ❒ Yes ❒ No
Has your child ever had any pain, tenderness, and/or clicking in the tempromandibular joint (TMJ)? ❒ Yes ❒ No
PLEASE DESCRIBE ANY "YES" ANSWERS: ____

____

Does your child have good oral hygiene habits? ❒ Yes ❒ No   Dentist Name:

____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's health status.

Print Name: ______________________ *Signature and Date:* ______________________

Andrew J. Kuhlberg DMD, MDS
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Dr Signature:

Please See Reverse