McConnell ORTHODONTICS

changing smiles changing lives

PATIENT INFORMATION – CHILD/TEEN

Patient Name (first, middle, last)_____

Nickname (if preferred)_____ ❑ Male ❑ Female Date of Birth _____

Home Phone_____ Work_____ Cell _____

Address _____ City/State/Zip _____

Current General Dentist _____ How long since your last dental visit? _____

What are your primary goals for orthodontic treatment: _____

How did you hear about our office? _____

Have we treated another member of your family? ❑ Yes ❑ No If Yes, name(s)_____

Name of individual filling out this form (first, middle, last) _____

Relationship to Patient _____ Do you have legal custody ❑ Yes ❑ No

Has your child visited an orthodontist before? ❑ Yes ❑ No If Yes, name(s)_____

What are the main concerns that you would like orthodontics to correct? _____

Is there anything that you would like to discuss with Dr. McConnell in private? ❑ Yes ❑ No

PARENTS' INFORMATION

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Email_____ (will not be shared with third parties)

Father

Name (first, middle, last)_____ ❑ Father ❑ Step-Father ❑ Guardian

Address (if different than child) _____

Social Security No. _____ Date of Birth _____

Home Phone_____ Work_____ Cell _____

Employer _____ Occupation _____ Employer's Phone _____

If **Father** has insurance coverage for this child, please fill out the following information

Insurance Company _____ Insurance Company's Phone _____

Insurance Company's Address_____

Group # _____ Policy # _____

Mother

Name (first, middle, last)_____ ❑ Mother ❑ Step-Mother ❑ Guardian

Address (if different than child) _____

Social Security No. _____ Date of Birth _____

Home Phone_____ Work_____ Cell _____

Employer _____ Occupation _____ Employer's Phone _____

If **Mother** has insurance coverage for this child, please fill out the following information

Insurance Company _____ Insurance Company's Phone _____

Insurance Company's Address_____

Group # _____ Policy # _____

(over)

DENTAL AND MEDICAL HISTORY

Is the child currently under the care of a physician? ❑ Yes ❑ No If Yes, for what reason _____

Child's Physician _____ Date of Last Physical (month/year) _____

History of major illness? ❑ Yes ❑ No If Yes, please describe _____

History of trauma or injury to the face or teeth? ❑ Yes ❑ No If Yes, please describe _____

_____

Any sensitivities or allergies (latex, antibiotics, etc.)? ❑ Yes ❑ No If Yes, please list _____

Currently taking any medications? ❑ Yes ❑ No If Yes, please list _____

Has the child been treated for any of the following?

❑ Arthritis ❑ Blood Disorder ❑ Diabetes ❑ Heart Condition ❑ Tuberculosis

❑ Asthma ❑ Cancer ❑ Epilepsy ❑ Nervous Disorder ❑ ADD/ADHD

Does the child require antibiotics prior to dental treatment? ❑ Yes ❑ No

Have the Adenoids or Tonsils been removed? ❑ Yes ❑ No

Has the child ever had pain or tenderness in the jaw joint (TMJ)? ❑ Yes ❑ No

Does/Did the child have any of the following habits?

❑ Teeth Grinding ❑ Finger/Thumb Sucking ❑ Prolonged Bottle/Pacifier

❑ Mouth Breathing ❑ Speech Problems ❑ Chewing/Eating Problems

SIGNATURE

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 medical status.

I hereby authorize the release of any information related to processing of insurance. I consent to examination by the doctor and authorize payment of any insurance benefits directly to this office.

Signature _____ Date _____