Orthodontics
Child Patient Information

Welcome!

Thank you for selecting our office for your orthodontic evaluation. Please help us by completing this orthodontic health questionnaire. If you have any questions or need assistance, please ask us. We will be happy to help you.

Patient Information (confidential)

Patient's Name **Date** ______________________

____
Last First Middle Initial Nickname

Age ____________ Date of Birth ________________ Sex ______________________

Address

Street ________________________________ Apt. # ________________

City ________________________________ State __________ Zip __________

Home Phone ____________ Cell ____________ E-mail ______________________

School ________________________________ Grade ________________

Father's Name ______________ Employer ______________ Work Phone ______________

Mother's Name ______________ Employer ______________ Work Phone ______________

Marital Status of parents: ◯ Married ◯ Separated ◯ Divorced ◯ Single

Whom may we thank for recommending our office to you?

◯ Self ◯ Dentist ◯ Insurance Company ◯ Online Search ◯ Others ______________

Responsible Party

Person responsible for financial matters:

Name ______________________ Home Phone ______________ Cell ______________

Address ______________________ City ______________ State ________ Zip ________

Employer ______________________________ Work Phone ______________________

E-mail ______________________________ Social Security # ______________________

Insurance Information

If you have orthodontic insurance, please complete the following (the person's information the insurance is under):

Name of the Insured ______________________ Relationship to patient ______________

Insured's Social Security # ______________________ Date of Birth ______________

Name of Insurance Company ______________________ Group # ______________________

Ins. Co. Address ______________________ City ______________ State ________ Zip ________

Ins. Co. Phone No. ____

Concerns

Describe the reason for the consultation. ______________________________

Is the patient aware of the orthodontic problem? ◯ Yes ◯ No

Has the patient had previous orthodontic consultation or treatment? ◯ Yes ◯ No

Which of the following best describes the patient's interest in orthodontic treatment?

◯ Patient wants treatment. ◯ Willing if treatment is necessary. ◯ Unwilling, but agrees.