Westfall ORTHODONTICS

CHILD PATIENT FORMS

Patient Information

First Name: Middle Name: Last Name:

Nickname: SEX: ☐ Male ☐ Female

Birth Date: Age: SSN:

School: Grade: College:

Hobbies/Sports

Street Address: City: State/Province Zip Code:

Email Address: Cell Phone:

Who is accompanying you today? Relation to you?

Does this person have legal custody of you? ☐ Yes ☐ No

Dentist's Name: Phone: Date of Last Visit:

Physician's Name: Phone: Date of Last Visit:

Other Family Members Seen By Us:

How did you hear about us?

Guardian One Information

First Name: Middle Name: Last Name:

Birth Date: Work Phone: Home Phone: Cell Phone:

Street Address: City: State/Province Zip Code:

Email Address: Employer: Does this patient live with you full time? ☐ Yes ☐ No

Guardian Two Information

First Name: Middle Name: Last Name:

Birth Date: Work Phone: Home Phone: Cell Phone:

Street Address: City: State/Province Zip Code:

Email Address: Employer: Does this patient live with you full time? ☐ Yes ☐ No

Person Responsible Account

First Name: Middle Name: Last Name:

Birth Date: Relation to Patient: Employer:

Driver License Number: SSN: Work Phone: Home Phone:

Billing Address: City: State/Province Zip Code:

Do you have orthodontic insurance? ☐ Yes ☐ No

Insurance Co: Group #: ID #:

Medical History

Question	Yes	No
Have you ever been evaluated or had orthodontic treatment before?	☐ Yes	☐ No
Have you been informed of any missing or extra permanent teeth?	☐ Yes	☐ No
Do you still have your wisdom teeth?	☐ Yes	☐ No
Have you experienced problems with previous dental work?	☐ Yes	☐ No
Have you ever had any pain / tenderness in your jaw joint (TMJ/TMD)?	☐ Yes	☐ No
Has your jaw ever clicked, popped or locked?	☐ Yes	☐ No
Have you noticed your teeth shifting or a change in your bite?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you floss your teeth daily?	☐ Yes	☐ No
Have there been any injuries to your face, mouth, teeth or chin?	☐ Yes	☐ No
Do you need to be premedicated before dental work?	☐ Yes	☐ No
Have adenoids or tonsils been removed?	☐ Yes	☐ No
Do you brush your teeth daily?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No
Are you taking fluoride supplements?	☐ Yes	☐ No
Are Immunizations current?	☐ Yes	☐ No
Boys:Has puberty begun?	☐ Yes	☐ No
Boys:Has your voice changed?	☐ Yes	☐ No
Girls: Has puperty begun?	☐ Yes	☐ No
Girls: Do you take birth control pills?	☐ Yes	☐ No
Girls: Are you pregnant?	☐ Yes	☐ No

Please list all medications that you are currently taking:

Are you Allergic to any of the following?

☐ Aspirin ☐ Any Metal ☐ Plastic ☐ Codeine
☐ Dental Anesthetics ☐ Erythromycin ☐ Latex ☐ Penicillin
☐ Tetracycline ☐ Sulfa Drugs ☐ Other ☐ None

Please list any other Allergies that you have:

Do you now have or have you had any of the following habits?

☐ Tongue Thrust ☐ Clenching/Grinding Teeth ☐ Lip Sucking/Biting
☐ Speech Problems ☐ Mouth Breather ☐ Nail Biting
☐ Other ☐ None

Please list any other Habits that you have:

Do you now have or have you had any of the following?

☐ Allergies
☐ Abnormal/Bleeding Disorders
☐ Any Hospital Stays
☐ Astma
☐ Cancer
☐ Canker Sores
☐ Cardiovascular Disease
☐ Chicken Pox
☐ Cold Sores/Fever Blisters
☐ Convulsions/Epilepsy
☐ Damaged/Artificial Heart Valves
☐ Diabetes
☐ Handicaps/Disabilities
☐ Hearing Impairment
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis/Liver Problems
☐ High Blood Pressure
☐ Hives
☐ HIV+/AIDS
☐ Kidney Problems
☐ Measles
☐ Mononucleosis
☐ Psychological Counseling
☐ Rheumatic/Scarlet Fever
☐ Skin Rash
☐ Tuberculosis (TB)
☐ Tumors/Growths
☐ Ulcers
☐ None

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. We reserve the right to verify the credit status prior to extending credit for treatment. I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the medical status of the patient named herein. Additionally, I hereby consent to an initial examination of the patient named herein.

Signature: ______________________________ Date: ________________