Macomb Orthodontics

Child New Patient Information Form (Under 18)

Patient Information

______________ Today's Date

Patient's Name: ______________ Last ______________ First ______________ Middle

Address: ______________ Street ______________ City ______________ Zip Code

Parent/Guardian: ______________ Name ______________ Relationship **Patient's Date of Birth:** ______________ MM/DD/YY

Phone Number: ______________ Primary Contact H / W / C Number Type ______________ Secondary Contact H / W / C Number Type

Sibling's name(s) and age(s): ______________

Friends / Family treated here: ______________

Email Address: ______________

PLEASE FILL IN YOUR PREFERRED METHOD OF APPOINTMENT CONFIRMATION

Email: ______________ **Text Message:** ______________

How did you hear about Macomb Orthodontics?
(Please fill in or circle all that apply)

Friend / Family ______________ Name **Dental Professional** ______________ Name

Drive By	Newspaper	Television	School/ Church Function
Internet	Direct Mailer	Team Sponsorship	Community Event

Are you on Social Media Yes / No

We Are! Find us on

Responsible Party Information

(Contact Information Required *Only* if Different from Above)

Responsible Party #1: ______________ Last ______________ First ______________ Middle

Relationship to patient: ______________ **Legal Guardian?** Yes / No

Address: ______________ Street ______________ City ______________ Zip Code

Phone Number: ______________ Primary Contact H / W / C Number Type ______________ Secondary Contact H / W / C Number Type

Date of Birth: ______________ MM/DD/YY **Employer:** ______________ **Occupation:** ______________

Responsible Party #2: ______________ Last ______________ First ______________ Middle

Relationship to patient: ______________ **Legal Guardian?** Yes / No

Address: ______________ Street ______________ City ______________ Zip Code

Phone Number: ______________ Primary Contact H / W / C Number Type ______________ Secondary Contact H / W / C Number Type

Date of Birth: ______________ MM/DD/YY **Employer:** ______________ **Occupation:** ______________

Are the Parties Listed Above Currently Married? **Yes / No**

Emergency Contact Information

(Nearest friend / relative not living with you)

Name: ______________ Last ______________ First ______________ Relationship to Patient

Contact Information: ______________ Address ______________ Phone Number

Dental Insurance-Primary

Subscriber Name: ______________________ **Birth Date:** ____________

Insurance Company Name: ______________________ **Phone Number:** ____________

Insurance Company Address: ______________________

Member ID# / SS#: ______________________ **Group #:** ____________

Dental Insurance-Secondary

Subscriber Name: ______________________ **Birth Date:** ____________

Insurance Company Name: ______________________ **Phone Number:** ____________

Insurance Company Address: ______________________

Member ID# / SS#: ______________________ **Group #:** ____________

Dental History

Dentist Name: ______________________ **Phone Number:** ____________

Address: ______________________ **Last Visit:** ____________
MM/DD/YY

I authorize Macomb Orthodontics to share clinical information with other dental professionals to ensure optimal dental health and best possible results. ____________
Signature

Please Circle Yes or No (If Yes, Please provide details)

Is patient presently in any dental pain?	YES / NO	
Does patient have bleeding gums or periodontal problems?	YES / NO	
Does patient suffer from tooth pain or sensitivity?	YES / NO	
Does patient get chronic canker sores in or near the mouth?	YES / NO	
Does patient have history of injury to face/mouth/teeth?	YES / NO	
Does patient have any thumb/finger-sucking or tongue habits?	YES / NO	
Does patient have history of speech problems?	YES / NO	
Does patient avoid or struggle with tooth brushing?	YES / NO	
Does patient suffer tension headaches, jaw soreness, popping or clicking?	YES / NO	
Has patient had any teeth removed? (Baby or Permanent)	YES / NO	
Does patient have fear/anxiety over dental appointments?	YES / NO	
Is patient self conscious about their teeth?	YES / NO	
Has anyone in your family received orthodontic treatment?	YES / NO	
Has patient been seen by an orthodontist? If yes, Who and When?	YES / NO	

What is your primary concern? (Why are you here today?) ______________________

What would you like to hear about today? (Circle all that apply) Metal Braces Clear Braces Invisalign

General Health History

Physician Name: ______________________ **Phone Number:** ____________

Has the patient started puberty? YES / NO If yes, When? (Approx.) ____________

Has the patient undergone their growth spurt? (sudden change in height and shoe size) YES / NO

Females- Has the patient started her monthly periods? YES / NO If yes, When? (Approx) ____________

Is the patient pregnant? YES / NO

Does the patient smoke or use tobacco products? YES / NO If yes, How often? ____________

Allergies

(If yes, Please list material and reaction)

Does the patient have an allergy to any medications? YES / NO (If yes, list all that apply)

Does the patient have an allergy or sensitivity to Latex / Vinyl / Acrylic YES / NO

Does the patient have an allergy or sensitivity to any Metals (Nickel etc.) YES / NO

Does the patient have any food allergies? YES / NO

Does the patient have seasonal or pet allergies? YES / NO

Medications

Please list all medication or supplements the patient is currently taking

Name ____ Taken for ____

Name ____ Taken for ____

Name ____ Taken for ____

Name ____ Taken for ____

Name ____ Taken for ____

Does the patient require pre-medication prior to any dental work **YES / NO**

Does patient or direct family member currently have, or have history of any of the following conditions:
Circle all that apply- (Yes) for patient, (Family) for family member, (No) for no history

Condition				Condition			
Birth Defects	Yes	No	Family	Pneumonia, Tuberculosis, Polio, Mononucleosis	Yes	No	Family
Asthma / Hay Fever	Yes	No	Family	Tumors/Cancer, Radiation or Chemotherapy	Yes	No	Family
Bone Disorders	Yes	No	Family	Bleeding disorder, Abnormal Bruising	Yes	No	Family
Herpes	Yes	No	Family	Gastrointestinal Disorders	Yes	No	Family
Fainting / Dizziness	Yes	No	Family	Neurological Disorder / Epilepsy	Yes	No	Family
HIV / AIDS	Yes	No	Family	Hepatitis, Jaundice or Liver problems	Yes	No	Family
Diabetes	Yes	No	Family	Rheumatoid or Arthritic Conditions	Yes	No	Family
Tonsil/Adnoid Condition	Yes	No	Family	Endocrine or Thyroid problems	Yes	No	Family
Frequent Headaches	Yes	No	Family	Vision, Hearing, Taste or Speech difficulties	Yes	No	Family
Kidney Problems	Yes	No	Family	Heart Problems- Murmurs, Defects, Disease	Yes	No	Family
Abnormal Blood Pressure	Yes	No	Family	Chest Pain, Shortness of Breath, Swollen Ankles	Yes	No	Family
Eating Disorders	Yes	No	Family	Sudden Weight Loss, Poor Appetite	Yes	No	Family
Tires Easily	Yes	No	Family	Mental Health, Depression, Behavioral problems	Yes	No	Family
Sleep Apnea	Yes	No	Family	Substance Abuse	Yes	No	Family

If you answered yes to any question, list details here:

Does patient have a history of surgery or hospitalization? YES / NO

If yes, Please explain:

Are there any additional medical/mental conditions not mentioned above? YES / NO

If yes, Please explain:

Does patient have learning disabilities or need assistance with instructions? YES / NO

If yes, Please explain:

Authorizations

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this record of medical or dental status, I will inform the practice.

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

I understand that where appropriate, credit bureau reports may be obtained.

Parent / Guardian Signature: