WESTCHESTER
family orthodontics

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Welcome to our office.
Please allow us to get to know you better by filling out both sides of this questionnaire

Date _____

PATIENT INFORMATION:

Name _____ _____ _____ _____ _____
Last First Preferred Name Middle Sex

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____ Home Phone _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office? _____

PARENT OR GUARDIAN INFORMATION:

Name _____ _____ _____ _____
Last First Middle Marital Status

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____ Financially responsible for this account ☐Yes ☐No

Name _____ _____ _____ _____
Last First Middle Marital Status

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____ Financially responsible for this account ☐Yes ☐No

INSURANCE INFORMATION:

Policy Owner's Name _____ Policy Owner's Employer _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Do You Have Dual Coverage? _____

GENERAL INFORMATION:

School/Grade _____

Brothers/Sisters (include ages) _____

Hobbies/Sports/Musical instruments played _____

MEDICAL HISTORY:

Physician _____ Phone _____ Last Visit _____

Is the child currently under the care of a physician? ☐Yes ☐No If yes, explain _____

Has puberty begun? ☐Yes ☐No Has menstruation (period) begun? ☐Yes ☐No ☐N/A

Is the child allergic to any of the following? ☐Yes ☐No If yes, please check all that apply

☐Aspirin ☐Codeine ☐Tetracycline ☐Any Metals/Plastics Other Allergies/Sensitivities

☐Erythromycin ☐Penicillin ☐Latex

Please list all medications the patient is currently taking

Please list any serious medical condition(s) treated in past or present

DENTAL HISTORY:

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

Has the patient ever been evaluated for orthodontic treatment? ☐Yes ☐No

Have the patient's tonsils or adenoids been removed? ☐Yes ☐No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐Yes ☐No

Does the patient have any missing or extra permanent teeth? ☐ Yes ☐No

Has the patient ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Does the patient have speech problems? ☐Yes ☐No If Yes, explain _____

Does/Has the patient ever had any of the following habits? ☐ Yes ☐No If yes, please all that apply

☐ Lip Sucking/Biting ☐Nail Biting ☐Prolonged Bottle/Pacifier ☐Clenching/Grinding Teeth

☐ Mouth Breather ☐Tongue Thrusting ☐Thumb/Finger Sucking

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 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 insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian _____ Date _____