PATIENT INFORMATION - CHILD

ALL ABOUT YOUR CHILD

Name: _____
Last First MI
Nickname: _____
Male ☐ Female ☐ Birthdate ___ ___ ___ Age _____
School: _____ Grade _____
Hobbies/Sports _____
Child's Home # (___) _____
Child's Home Address _____
City _____ State ___ Zip _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____
Relation: _____
Parent's Marital Status: _____
Do you have legal custody of this Child? _____
Whom may we thank for referring you? _____
Other immediate family members seen by us: _____

DENTIST

General Dentist: _____
Date of Last Exam: _____

☐ MOTHER ☐ STEP MOTHER ☐ GUARDIAN

Name: _____
First Last
Employer: _____
Work # ( ) Ext:
Home # ( )
Email: _____
How long at current job? _____ Title: _____
Do you have dental insurance with orthodontic coverage? _____

☐ FATHER ☐ STEP FATHER ☐ GUARDIAN

Name: _____
First Last
Employer: _____
Work # ( ) Ext:
Home # ( )
Email: _____
How long at current job? _____ Title: _____
Do you have dental insurance with orthodontic coverage? _____

Who will be responsible for making appointments? _____
Who will be responsible for the account? _____

Dr. Alisa J. Raglin, D.D.S.
Specializing in Orthodontics
www.raglinortho.com

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

	Yes	No
Has your child ever had or been evaluated for orthodontic treatment?		
Have there ever been any injuries to the face, mouth, teeth or chin?		
Has your child ever been diagnosed with any missing or extra permanent teeth?		
Does your child brush his/her teeth daily?		
Floss his/her teeth daily?		
Has puberty began?		
Has menstruation began? (Girls)		
Has your child ever experienced pain or discomfort in their jaw joint (TMJ/TMD)?		

Child's Physician: _____
Phone # _____
Is your child currently under the care of a physician? _____
Please list all drugs your child is currently taking: _____
_____
Please list all drugs/things your child is allergic to: _____
_____

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Allergies to any drugs
Y	N	Allergic to Latex/Metals	Y	N	Allergic to Plastic
Y	N	Asthma	Y	N	Cancer
Y	N	Congenital Heart Defects	Y	N	Convulsions/ Epilepsy
Y	N	Diabetes	Y	N	Handicaps/Disabilities
Y	N	Hearing impairment	Y	N	Heart Murmur
Y	N	Hemophilia	Y	N	Hepatitis
Y	N	HIV+/ AIDS	Y	N	Hospitalization
Y	N	Kidney/Liver Problems	Y	N	Operations
Y	N	Rheumatic / Scarlet Fever	Y	N	Tuberculosis

Please list any other medical problems that your child has or have had: _____
_____
_____

Has your child ever had any of the following habits?

Y	N	Clenching/Grinding	Y	N	Lip Sucking/Biting
Y	N	Nail Biting	Y	N	Tongue Thrusting
Y	N	Mouth Breathing	Y	N	Thumb/Finger Sucking
Y	N	Soda Drinker			

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

_____
Signature of parent or guardian Date

_____
Reviewed Date