



Welcome to F&S Orthodontics and Periodontics
Function and Smile Confidently

Child Information

Child's Full Name: Preferred Name: Birth Date:
Address: City: State: Zip:
School: Grade: Send appointment reminders by: Text E-mail
Dentist Name: Date of last dental cleaning:
How did you hear about us?: Dentist Google Friend/Family Whom may we thank?
Sports/Hobbies/Activities?

Parent/Guardian Information

Full Name: Relationship to child: Birth Date:
Address (if different than child): City: State: Zip:
Phone: H C Email: SSN:
Employer: Work Phone: How long employed:
Marital Status: Married (Spouse's Name:) Separated Divorced Widowed Single

Full Name: Relationship to child: Birth Date:
Address (if different than child): City: State: Zip:
Phone: H C Email: SSN:
Employer: Work Phone: How long employed:
Marital Status: Married (Spouse's Name:) Separated Divorced Widowed Single

Child lives with (check all that apply):

Mother Father Stepmother Stepfather Grandparent(s) Other
Who will be responsible for scheduling child's appointments?
Who will be responsible for bringing child to appointments?
Who will be financially responsible for child's account?

Dental Insurance Information Only

Not covered by dental insurance (If no insurance, skip to next page)

Please provide us with your insurance card(s) so we can make a copy

Policy Holder Name: Insurance Company Name:
Group Number: ID/Policy Number (may be SSN):
Insurance Mailing Address (back of card):

Covered by secondary dental insurance? Yes No

Policy Holder Name: Insurance Company Name:
Group Number: ID/Policy Number (may be SSN):
Insurance Mailing Address (back of card):

Medical and Dental History

Main reason you contacted our office for an exam: _____

Has your child ever been examined by an orthodontist/periodontist before? Yes No

Did you pursue treatment? Yes No

Please explain: _____

Does your child have any history of the following?

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, or heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood Transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Does your child have any history of the following?

- Multiple cavities
- Teeth extracted
- Teeth abscessed
- Gum disease
- Nail or lip biting or thumb sucking
- Tongue thrust
- Poor dental hygiene
- Mouth breathing more than nose breathing
- Tonsils and/or adenoids removed
- Pain or ringing from ears
- Frequent ear infections, sinusitis, or swollen glands
- Need to take antibiotics before dental treatment
- Automobile accident causing dental trauma
- Obstructive sleep apnea
- Snoring or difficulty sleeping

Is there anything else you would like us to know about your child? _____

Is your child allergic to or reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Is your child taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medication
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drugs
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medication
- Other: _____

Females:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Does your child have any history of the following issues related to the Temporomandibular Joint (TMJ)?

- TMJ problems
- Clicking, popping, or noise from the jaw during opening or closing
- Teeth clenching or grinding
- Pain upon wide opening, yawning, or biting hard foods
- Frequent neck, shoulder, or back pain
- Injuries to teeth, chin, head, or face (falls, blows, etc.)
- Prosthetic joint replacement of the TMJ

Does your child smoke or use chewing tobacco? Yes No

Signature of Parent/Guardian: _____ Date: _____