DR. Heather Brown Orthodontics
The Secret Behind a Beautiful Smile...

Today's date _____/_____/_____

**NEW PATIENT**

*We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## PATIENT INFORMATION - CHILD

○ MALE ○ FEMALE

Patient's Name _____ Age_____ Birth Date ____/____/_____
FIRST | MIDDLE | LAST — MM DD YYYY

Nickname (if preferred) _____ Email @_____
PARENT/GUARDIAN'S EMAIL ADDRESS

Home phone _____ Cell Phone _____ SS # _____/_____/_____

Home address _____ City/State/Zip _____ , _____ , _____
STREET

Who is filling in this form? _____
FIRST | MIDDLE | LAST

Relationship _____ Do you have legal custody? ○ YES ○ NO

Patient's General Dentist _____ Who referred you to our office? _____

Have we treated another member of your family? ○ YES ○ NO. If Yes, Who? _____

What are the main concerns you have about your child's teeth? _____

Has your child visited an orthodontist before ○ YES ○ NO. If Yes, did your child begin treatment? _____

## PARENTS INFORMATION

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

### *MOTHER*

○ Mother ○ Step Mother ○ Guardian Name _____
FIRST | MIDDLE | LAST

Address *(if different than child's)* _____ Birth Date _____/_____/_____
MM DD YYYY

Home phone _____ Work Phone _____ Cell Phone _____ SS # _____/_____/_____

Employer _____Employer Address _____ Employer's # _____

**If you have insurance coverage for the child, please fill out:**

Insurance Company Name _____ Group or Plan _____

Insurance Company Phone _____Insurance Company Address _____

### *FATHER*

○ Father ○ Step Father ○ Guardian Name _____
FIRST | MIDDLE | LAST

Address *(if different than child's)* _____ Birth Date _____/_____/_____
MM DD YYYY

Home phone _____ Work Phone _____ Cell Phone _____ SS # _____/_____/_____

Employer _____Employer Address _____ Employer's # _____

**If you have insurance coverage for the child, please fill out:**

Insurance Company Name _____ Group or Plan _____

Insurance Company Phone _____Insurance Company Address _____

## DENTAL AND MEDICAL HISTORY

Is the child under the care of a physician? ◯ YES ◯ NO. If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? ◯ YES ◯ NO. If YES, Please describe _____

Any sensitivities or allergies? ◯ YES ◯ NO. If YES, please list _____

Currently taking any medications? ◯ YES ◯ NO. If YES, please list _____ Reason _____

Has the child been treated for any of the following?

◯ Autism ◯ ADHD ◯ Depression ◯ Diabetes ◯ Herpes ◯ Heart Condition ◯ Cancer

◯ Asthma ◯ HIV/AIDS ◯ Hepatitis ◯ Epilepsy ◯ High Blood Pressure ◯ Tuberculosis ◯ Other _____

Does the child require antibiotics before dental treatment? ◯ YES ◯ NO. If YES, Please explain _____

Have there been any injuries to the face, mouth or chin? ◯ YES ◯ NO.

Has the child ever had any pain/tenderness in their jaw joint? (TMJ/TMD) ◯ YES ◯ NO. Are you pregnant? ◯ YES ◯ NO.

Does/Did the child have any of the following habits?

◯ Grinding Teeth ◯ Finger/thumb sucking ◯ Tongue Thrusting

◯ Chronic Mouth Breathing ◯ Speech Problems ◯ Chewing/ Eating Problems

Is there anything else about your child's medical history that we should be aware of? _____

## SIGNATURE

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

SIGNATURE _____ DATE _____/_____/_____

## OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
Initials: _____ Date _____/_____/_____

**Doctor's comments:** _____

_____

_____

**Medical History Update:**

1. Date _____/_____/_____ Signature: _____

Comments: _____

2. Date _____/_____/_____ Signature: _____

Comments: _____