NEW PATIENT INFORMATION QUESTIONNAIRE
(Child)

IMPORTANT: Please fill out this patient questionnaire and bring your insurance forms (with the employee's sections filled out and signed if applicable) to your first appointment at our office.

PLEASE PRINT Date:_______________________________________

PATIENT NAME: Last __________________________________ First ____________________________ Middle __________________

Nickname (if any) _______________________________ Birthdate ____

Home Phone (______) _______________________________ Sex _______ Height ________ Weight _______ Age ___________

Address ____ City _____________________________ Zip _____________

School _______________________ Grade _________ E-Mail Address ____

Circle One: Parents Are: Married Widowed Divorced Separated

FINANCIALLY RESPONSIBLE PERSON(S):

Name ____ ____
Last First MI — Relationship to Patient

____ (_____) _______________ (_____)________________
Address City Zip — Home Phone — Cell/Daytime Phone

____ _______-_______-_________ ______________ _____
Previous Address City Zip — Social Sec. No. — Birthdate — Age
(If less than 3 years at present address)

____
Driver's Lic. No.

____ ________________________ ____________________
Employer — Occupation — # Years Employed

____ ________________________ (_____)______________
Spouse's First Name MI Last — Spouse's Employer — Cell/Daytime Phone

= =

Name ____ ____
Last First MI — Relationship to Patient

____ (_____) _______________ (_____)________________
Address City Zip — Home Phone — Cell/Work Phone

____ _______-_______-_________ _____________ ______
Previous Address City Zip — Social Sec. No. — Birthdate — Age
(If less than 3 years at present address)

____
Driver's Lic. No.

____ _______________________________ ____________
Employer — Occupation — # Years Employed

____ ________________________ (____)______________
Spouse's First Name MI Last — Spouse's Employer — Cell/Work Phone

LET'S GET ACQUAINTED (to be completed by Child):

What's your favorite... Color? __________________ Sport? ___________________ School Subject? _______________________

What do you like to do in your spare time (hobbies, sports, recreation)? ____

____

Other stuff you'd like to tell us about yourself: ____

____

DENTIST: Name ____ Address ____

Phone (_____) ___________________________________ Date Last Checked ____________________________________

REFERRAL: Whom may we thank for referring you to our office? ____

Is anyone in your family having or had orthodontic work done in this office? (Specify) ____

Does father and mother have normal teeth? _______________Have they been treated for orthodontics? ______________________

(Continued)

DENTAL/ORTHODONTIC INSURANCE INFORMATION:

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Insured's Employer _____

Do you have dual coverage? Yes___ No___ If yes:

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Group No. _____ Local No. _____

DENTAL HISTORY

Yes	No	
☐	☐	Have there been any injuries to the face, mouth or teeth? If yes, explain: _____
☐	☐	Has the patient ever sucked his/her thumb or fingers? If so, until what age? _____
☐	☐	Has the patient undergone speech therapy?
☐	☐	Are you aware of any missing permanent teeth? If so, which ones? _____
☐	☐	Has the patient received any previous orthodontic treatment?

What is the chief complaint regarding your child's teeth: _____

Does child have or has child had the following habits:

Yes	No		Yes	No		Yes	No	
☐	☐	Thumb sucking	☐	☐	Pencil biting	☐	☐	Clenching
☐	☐	Finger sucking	☐	☐	Mouth breathing	☐	☐	Grinding (day or night)
☐	☐	Nail or lip biting	☐	☐	Tongue thrust	☐	☐	Other:_____

Does child have any of the following:

Yes	No		Yes	No	
☐	☐	Teeth sensitive to cold, heat, sweets or pressure	☐	☐	Pain around ear
☐	☐	Bleeding gums. If so, how long?	☐	☐	Unusual sounds in ear while eating
☐	☐	Food impaction	☐	☐	Bad breath
☐	☐	Burning of Tongue	☐	☐	Unpleasant taste
☐	☐	Swelling or lumps in mouth	☐	☐	Unfavorable dental experience
☐	☐	Frequent blisters on lips or mouth	☐	☐	Complications from extractions
			☐	☐	Periodontal treatment

Does child regularly:

Yes	No	
☐	☐	Brush _____ times a day
☐	☐	Floss daily
☐	☐	Use mouthwash

MEDICAL HISTORY

Patient's physician _____ Phone (_____) _____ Address: _____

Any medical or physical disorders? _____

Is child in good health? _____ Taking any medication now? _____

Is child under a physician's care now? _____ If so, please give reasons for treatment: _____

Does child experience or has child experienced:

Yes	No		Yes	No		Yes	No	
☐	☐	Chest pain (angina)	☐	☐	Diarrhea, constipation, blood in stools	☐	☐	Pregnancy or nursing (females only)
☐	☐	Swollen ankles	☐	☐	Frequent vomiting, nausea	☐	☐	Blurred vision
☐	☐	Shortness of breath	☐	☐	Difficulty urinating, blood in urine	☐	☐	Seizures
☐	☐	Recent weight loss, fever, night sweats	☐	☐	Dizziness	☐	☐	Excessive thirst
☐	☐	Persistent cough, coughing up blood	☐	☐	Ringing in the ears	☐	☐	Frequent urination
☐	☐	Bleeding problems, bruising easily	☐	☐	Headaches	☐	☐	Dry mouth
☐	☐	Sinus problems	☐	☐	Fainting spells	☐	☐	Jaundice
☐	☐	Difficulty swallowing				☐	☐	Joint pain, stiffness

Does child have or has child had:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart disease, Heart attack	☐	☐	Stomach problems, ulcers	☐	☐	Asthma
☐	☐	Heart murmurs	☐	☐	Allergies to drugs, food, medications	☐	☐	Eye disease
☐	☐	Rheumatic fever			List: _____	☐	☐	Skin diseases
☐	☐	Stroke, hardening of arteries	☐	☐	Allergies to latex gloves	☐	☐	Anemia
☐	☐	High blood pressure	☐	☐	Family history of diabetes, heart problems, tumors	☐	☐	VD (syphilis or gonorrhea)
☐	☐	TB, emphysema, other lung diseases				☐	☐	Herpes
☐	☐	Hepatitis, other liver disease	☐	☐	AIDS or ARC	☐	☐	Kidney, bladder disease
☐	☐	Nervous disorders	☐	☐	Tumors, cancer	☐	☐	Thyroid, adrenal disease
			☐	☐	Arthritis, Rheumatism	☐	☐	Taken Fen-Phen or appetite suppressants

(Over)

Does child have or has child had:

Yes	No		Yes	No		Yes	No	
☐	☐	Psychiatric care	☐	☐	Hospitalization	☐	☐	Drug, medicines (including aspirin and birth control pills) List: _____ _____
☐	☐	Radiation treatments	☐	☐	Blood transfusions	☐	☐	Recreational drugs
☐	☐	Chemotherapy	☐	☐	Surgeries	☐	☐	Tobacco in any form
☐	☐	Prosthetic heart valve	☐	☐	Pacemaker	☐	☐	Alcohol
☐	☐	Artificial joint	☐	☐	Contact lenses			

To your knowledge, does child take:

Does child or has child had any other diseases or medical problems NOT listed on this form? _____ If yes, explain: _____

Any other information we should know about your child's health? _____

_____

By signing this form, you acknowledge that the office of Abari Orthodontics has permission to examine your child and that the information provided by you is true and accurate. You agree to inform us of any change in your child's health and/or medication. As a patient in our practice, we share your child's medical/dental information with the dentist and any other dental professionals, insurance company and other sources in the course of the treatment. I hereby authorize payments directly to this office of the group insurance benefits otherwise payable to me.

Date _____ *Signature* _____

Date _____ *Signature* _____

Additionally, since we will be making financial arrangements regarding payment of this account and extending credit, where appropriate, you give us permission to obtain credit bureau reports.

Date _____ *Signature* _____

Date _____ *Signature* _____

OUR MISSION STATEMENT

It is our desire to provide a unique professional experience for all who encounter our office. To that end, we commit to treating with love and care our patients, parents, each other, and anyone else who comes to our office, placing their concerns before our own. We commit to providing excellence in our orthodontic treatment and to our goal of a balanced face, healthy jaw joints and beautiful smiles. Our primary concern is about relationships, not just about treatment of teeth.

Health History Review:

Year 2
Changes in Health: _____

Date:_____ Parent's Signature: _____ Doctor's Signature: _____

Year 3
Changes in Health: _____

Date:_____ Parent's Signature: _____ Doctor's Signature: _____

Year 4
Changes in Health: _____

Date:_____ Parent's Signature: _____ Doctor's Signature: _____