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CENTURY
Orthodontics
Our Third Century of Orthodontic Excellence

Members
American Association of
Orthodontists

(636) 391-0499

Manchester ▪ Clayton ▪ Wildwood

CHILD/ADOLESCENT INFORMATION

TODAY'S DATE ____/____/____

** Please complete and return by mail if you have the time. If not please bring completed form to the office. It will save you time at the office.*

Patient's Name _____ Nickname _____

Birth date _____ Age _____ School _____ Grade _____ Sex _____

Home Address _____ Internet Address _____

City _____ State _____ Zip _____ Phone # _____

Father's Name _____ Occupation _____ SS# _____

Address *(if different from child)* _____

City _____ State _____ Zip _____ Phone # _____

Employer, Name and Address _____

Mother's Name _____ Occupation _____ SS# _____

Address *(if different from child)* _____

City _____ State _____ Zip _____ Phone # _____

Employer, Name and Address _____

Parents are: ❑ Married ❑ Separated ❑ Divorced ❑ Unmarried Is patient adopted? ❑ Yes ❑ No

Patient living with: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other _____

Siblings (name & birthdate) _____

Person & address responsible for account _____

Insurance Father: _____ Mother: _____

Dentist _____ Date of last dental examination _____

Physician _____ Date of last complete examination _____

Physician Address _____

Have you completed all recommended dental work? ❑ Yes ❑ No

How did you come to choose our office *(indicate as many as applicable)*

❑ dentist referral ❑ insurance plan referral

❑ other family members treated at this office: Names _____

❑ recommendations of neighbors and friends: Names _____

❑ other (physician, Yellow Pages, dental society, etc.) _____

Has the patient had previous orthodontic consultation? ❑ Yes ❑ No Treatment? _____

When? _____ By? (dentist, orthodontist) _____

Did father have orthodontic problems? _____ Treated? _____ Mother? _____ Treated? _____

Height of Patient _____ Growth last year _____ Father's Height _____ Mother's Height _____

Describe patient's temperament _____

Patient will probably be: ❑ Eager to cooperate ❑ Cooperative ❑ Unwilling, but will go along ❑ Uncooperative

Do you anticipate a move or transfer in the near future? _____

What is the patient's (or parent's) primary concern (why are you here?) _____

_____

Please complete other side

Please check YES or NO. If Yes, please fill in details.

❑ Yes ❑ No Require **antibiotic** premedication before dental work? _____

❑ Yes ❑ No Birth defects, congenital abnormalities? _____

❑ Yes ❑ No Heart trouble? Congenital heart lesions? _____

❑ Yes ❑ No History of Rheumatic fever? _____

❑ Yes ❑ No High or low blood pressure? _____

❑ Yes ❑ No Anemic? _____

❑ Yes ❑ No Diabetes? _____

❑ Yes ❑ No Fainting or dizzy spells? When? _____

❑ Yes ❑ No Frequent headaches? How often? _____

❑ Yes ❑ No Epilepsy? Medication? _____

❑ Yes ❑ No Endocrine disorders? _____

❑ Yes ❑ No Asthma or hay fever? _____

❑ Yes ❑ No Sinus trouble? _____

❑ Yes ❑ No Speech or hearing disorders? _____

❑ Yes ❑ No Infectious hepatitis? Jaundice? Tuberculosis? Kidney disease? HIV positive? _____

❑ Yes ❑ No Emotional or Psychological disorder? _____

❑ Yes ❑ No Allergic to any medication? Metals? Latex?, etc.? _____

❑ Yes ❑ No Major operations or illnesses? _____

❑ Yes ❑ No Taking any medication? What? _____

❑ Yes ❑ No Do you have any growths, swelling, or sores in your mouth? _____

❑ Yes ❑ No Mouth breathing? _____

❑ Yes ❑ No Tonsil, Adenoid problems? _____

❑ Yes ❑ No Bleeding or swollen gums? _____

❑ Yes ❑ No Frequent canker (cold) sores? _____

❑ Yes ❑ No Habits (Thumb sucking, lip biting, nail biting?) _____

❑ Yes ❑ No Injuries to face, head or neck? _____

❑ Yes ❑ No Parts of mouth sensitive to temperature, pressure or food or drink? _____

❑ Yes ❑ No Stiff neck muscles? _____

❑ Yes ❑ No Clenching or grinding of teeth? _____

❑ Yes ❑ No Jaw clicking or popping while eating or yawning? _____

❑ Yes ❑ No Difficulty in opening mouth widely? _____

Please amplify answers on a separate sheet of paper if necessary.

Our Office Policy Is:

The parent who requests treatment for the child is responsible for all services rendered. We will however bill either party as a courtesy with this understanding. I also understand that, where appropriate, credit bureau reports may be obtained.

Signature _____ Relationship To Patient _____ Date _____