

Acadian ORTHODONTICS

CHILDREN

RICHARD H. MANESS, D.D.S., M.S.D.

1. TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____

Child's Name: _____ Age: _____

Last First Middle
Nickname: _____ Male Female

School: _____ Grade: _____

Home #: _____ Cell #: _____

Child's Home Address:

_____ Apt# _____

_____ City State Zip

2. WHO'S WITH THE CHILD TODAY?

Name: _____

Relation: _____

Do you have legal custody of this child? YES NO

Parent's Marital Status: _____
(single, married, divorced)

Who may we THANK for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Address: _____

Phone #: _____ Date Last Seen: _____

3. MOTHER'S INFORMATION:

Name: _____

Work #: _____ Ext. _____ Home #: _____

Cell # _____ DOB _____

Employer: _____

DL #: _____

SS #: _____

FATHER'S INFORMATION:

Name: _____

Work #: _____ Ext. _____ Home #: _____

Cell # _____ DOB _____

Employer: _____

DL #: _____

SS #: _____

4. RESPONSIBLE PARTY INFO:

Name: _____

Billing address: _____

_____ City State Zip

Work #: _____ Ext. _____ Home #: _____

Employer: _____

DL #: _____

SS #: _____

Who is responsible for making appointments?

Name: _____

Work #: _____ Ext. _____ Home #: _____

5. PRIMARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

6. WHY DID YOU BRING THE CHILD TO THE ORTHODONTIST TODAY?

- Y N Has the child ever had a serious/difficult problem associated with dental work?
- Y N Is the child's water fluoridated?
- Y N Is the child taking fluoridated supplements?
- Y N Does the child brush teeth daily?
- Y N Floss their teeth daily?

Child's Physician: _____

Phone#: _____ Date Last Seen: _____

Y N Is the child currently under the care of a physician?

Please describe the child's health:

GOOD FAIR POOR

Please list all drugs the child is currently taking:

Please list all drugs the child is allergic to:

7. HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|------------------|------------------------------|
| Y N Heart Murm. | Y N Congenital Heart Def. |
| Y N Cancer | Y N Convulsions/Epilepsy |
| Y N Diabetes | Y N Abnormal Bleeding |
| Y N Rheum. Fev. | Y N Hearing Impairment |
| Y N HIV+/AIDS | Y N Any Operations |
| Y N Hemophilia | Y N Any Stays in Hospital |
| Y N AstHomea | Y N Kidney/Liver Problems |
| Y N Hepatitis | Y N Handicaps/Disabilities |
| Y N Tuberculosis | Y N Allergies to Any Drugs |
| Y N Prosthesis | Y N History of Scarlet Fever |

Please discuss any serious medical problems that the child has had: _____

GIRLS ONLY

- Y N Has the patient started her monthly periods?
If so, approximately when? _____
- Y N Is the patient pregnant?

8. DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

- Y N Thumb sucking / Finger sucking
- Y N Lip sucking / biting
- Y N Nail Biting
- Y N Nursing Bottle Habits

9. DENTAL HISTORY

Now or in the past, has the patient had:

- Y N Permanent or "extra" (supernumerary) teeth removed?
- Y N Supernumerary (extra) or congenitally missing teeth?
- Y N Chipped or otherwise injured primary (baby) or permanent teeth?
- Y N Teeth sensitive to hot or cold; teeth throb or ache?
- Y N Jaw fractures, cysts or mouth infections?
- Y N "Dead teeth" or root canals treated?
- Y N Bleeding gums, bad taste or mouth odor?
- Y N Periodontal "gum problems"?
- Y N Food impaction between teeth?
- Y N "Gum boils," frequent canker sores or cold sores?
- Y N Thumb, finger, or sucking habit? Until what age _____?
- Y N Abnormal swallowing habit (tongue thrusting)?
- Y N History of speech problems?
- Y N Mouth breathing habit, snoring or difficulty in breathing?
- Y N Tooth grinding or jaw clenching?
- Y N Any pain, clicking or locking in jaw or ringing in the ears?
- Y N Any pain or soreness in the muscles of the face or around the ears?
- Y N Difficulty in chewing or jaw opening?
- Y N Have you ever been treated for "TMD" or "TMJ" problems?
- Y N Aware of loose, broken or missing restorations (fillings)?
- Y N Any teeth irritating cheek, lip, tongue or palate?
- Y N Concerned about spaced, crooked or protruding teeth?
- Y N Aware or concerned about under or over developed jaw?
- Y N Any relative with similar tooth or jaw relationships?
- Y N Any wisdom tooth problems?
- Y N Had periodontal (gum) treatment?
- Y N Been under another dentist's care?
Specialist _____ Other _____
- Y N Ever had a prior orthodontic examination or treatment?
- Y N Would you object to wearing orthodontic appliances (braces) should they be indicated?

Our office is committed to meeting or exceeding the standards of Infection Control mandated by OSHA, the CDC, and the ADA.

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

Signature of Parent/Guardian

Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.