Patient Information – Child

All About Your Child

Name: _____
First Last

Nickname: _____

Male:___ Female:___ Birthdate:____/____/____ Age: ___

School: _____ Grade:_____

Hobbies/sports: _____

Child's Home #: ( ) _____

Child's Home Address:_____

City: _____ State: _____ Zip: _____

Dentist

General Dentist: _____

Date of Last Exam: _____

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____
First Last

Birthdate: ____/____/____

Employer: _____

Work#: ( ) _____ Ext: _____

Home#: ( ) _____

Cell#: ( ) _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

☐ Father ☐ Step Father ☐ Guardian

Name: _____
First Last

Birthdate: ____/____/____

Employer: _____

Work#: ( ) _____ Ext: _____

Home#: ( ) _____

Cell#: ( ) _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Spoonhower Orthodontics

4030 Massillon Road
Suite B
Uniontown, Ohio 44685
T 330.896.0600
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www.smilebyspoon.com

What are your main concerns that you would like orthodontics to accomplish?: _____

Has your child ever had or been evaluated for orthodontic treatment? ☐Yes ☐No

Has there ever been any injuries to the face, mouth or chin? ☐Yes ☐No

Has your child ever been informed of any missing or extra permanent teeth? ☐Yes ☐No

Does your child brush his/her teeth daily? ☐Yes ☐No

Floss his/her teeth daily? ☐Yes ☐No

Has puberty begun? ☐Yes ☐No

Has menstruation begun? (Girls) ☐Yes ☐No

Does your child now have or ever experienced pain or discomfort in their jaw joint (TMJ/TMD)? ☐Yes ☐No

Child's physician: _____

Phone #: _____

Is your child currently under the care of a physician?:_____

Please list all drugs your child is currently taking: _____

_____

Please list all drugs/things your child is allergic to:_____

_____

Has your child ever had any of the following medical problems?

Y	N	Abnormal bleeding	Y	N	Rheumatic/Scarlet Fever
Y	N	Allergic to latex/metals	Y	N	Cancer
Y	N	Asthma	Y	N	Convulsions/epilepsy
Y	N	Congenital heart defects	Y	N	Handicaps/disabilities
Y	N	Diabetes	Y	N	Heart murmur
Y	N	Hearing impairment	Y	N	Hepatitis
Y	N	Hemophilia	Y	N	Hospitalization
Y	N	HIV positive/AIDS	Y	N	Operations
Y	N	Kidney/liver problems	Y	N	Tuberculosis

Please list any medical problems that your child has had:_____

_____

_____

Has your child ever had any of the following habits?

Y	N	Clinching/Grinding	Y	N	Lip Sucking/Biting
Y	N	Nail Biting	Y	N	Tongue Thrusting
Y	N	Mouth Breathing	Y	N	Thumb/Finger Sucking
Y	N	Soda Pop Drinker			

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

_____
Signature of parent or guardian Date

_____
Reviewed Date

Account & Insurance Information

Patient Name: _____ Date: _____

Birthdate: _____

Responsible Party

Name: _____

Relation: _____ SS#: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ Email: _____

Employer: _____ Work #: ( ) _____

Primary Dental Insurance

Policy Holder: _____

Relation: _____

Address: _____

City: _____

State: _____

Zip: _____

Home #: ( ) _____

SS#: _____

Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( ) _____ Ext: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

ID #: _____

Phone #: _____

Secondary Dental Insurance

Policy Holder: _____

Relation: _____

Address: _____

City: _____

State: _____

Zip: _____

Home #: ( ) _____

SS#: _____

Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( ) _____ Ext: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

ID #: _____

Phone #: _____