GROWING SMILES
Pediatric Dentistry & Orthodontics

About You

Today's Date: ____/____/_____ ☐ Male ☐ Female

Name: _____

Preferred Name: _____ Marital Status: S M D W

Birthdate: ___/___/_____ Age: ____ SSN: _____

Address: _____

_____

Email: _____

Employer: _____

How Long There? _____ Occupation: _____

Home Phone: _____ Cell: _____

Work Phone: _____

Whom may we thank for referring you? _____

Preferred appointment reminder method:

☐ Email _____

☐ Text # _____

Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID # _____

Group # _____

Insured's Name _____

Insured's Birthdate _____/_____/_____

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID # _____

Group # _____

Insured's Name _____

Insured's Birthdate _____/_____/_____

Spouse's Information

His/Her Name: _____

Employer: _____

Work Phone: _____ Cell: _____

Birthdate: _____/_____/_____

In the event of an emergency, whom would you like us to contact?

His/Her Name: _____

Relation: _____

Home Phone: _____ Cell: _____

Dental and Medical History

General Dentist: _____ Phone: _____

Address: _____

Last Cleaning: ____/____/_____

Have you ever been evaluated for or had orthodontic treatment before? Y / N

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

_____

Do you or have you experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y / N

Grind Teeth? Y / N Mouth Breather? Y / N Missing Teeth? Y / N

Have ☐ Tonsils ☐ Adenoids been removed?

Have you experienced any unfavorable reaction to any previous dental or medical care? Y / N

Do you require antibiotics before dental procedures? Y / N

If Yes, please specify and give a reason for this need: _____

Family Physician: _____ Phone: _____

Address: _____

Are you currently under a physician's care? Y / N If yes, please specify: _____

Are you taking any medicine at this time? Y / N If yes, please specify: _____

Are you taking any medications? Y / N If yes, please specify: _____

Do you have any known allergies? Y / N If yes, please specify: _____

Have you been hospitalized or had any surgeries? Y / N If yes, please specify: _____

Do you have any history of these (Circle all that apply)?

Yes / No Allergies	Yes / No Lung Disorder	Yes / No Heart Disorder/ Murmur	Yes / No Speech Difficulties
Yes / No Anemia	Yes / No Breathing Difficulties	Yes / No Hypertension	Yes / No Emotional Disorders
Yes / No Prolonged bleeding/clotting disorder	Yes / No Asthma	Yes / No Congenital Heart Disease	Yes / No Hearing Difficulties
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Rheumatic fever	
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Endocrine/Hormone disorders	
Yes / No Artificial Joint	Yes / No Neurological Disorder	Yes / No Diabetes	
Yes / No AIDS or HIV	Yes / No Cerebral palsy	Yes / No Hepatitis or Liver Disorder	
Yes / No ADD/ADHD	Yes / No Convulsions/ Seizures	Yes / No Kidney or Bladder Disorder	

If you are experiencing or have a history of any disease, condition or problem not addressed, please explain:

_____

Signature: _____ Date: _____