CAMAS ORTHODONTICS

Date: _______________

Child Patient Information

Patient name: ____________ ____________ ______ ____________ ____________
Last First M.I. Preferred name (Preferred Pronoun)

DOB: ____________ How did you hear about our office? ______________________

Residence address: ______________________________________
Street City State Zip

Preferred phone number: ______________ Patient's cell (if applicable): ______________

Responsible Party No. 1

Responsible party: ____________ ____________ Marital status: ○ Single ○ Married ○ Divorced
Last First

Responsible party's DOB: ____________ Relationship to patient: ______________________

Cell phone: ____________ Home phone: ____________ Email: ______________________

Residence address: ______________________ ○ Rent ○ Own No. of years at this address? ______

Mailing address: ______________________ Previous address: ______________________
*if different than above *if less than 3 years

Employer: ______________ Occupation: ______________ No. years employed? ________

Responsible Party No. 2

Responsible party: ____________ ____________ Marital status: ○ Single ○ Married ○ Divorced
Last First

Responsible party's DOB: ____________ Relationship to patient:______________________

Cell phone: ____________ Home phone: ____________ Email:______________________

Residence address: ______________________ ○ Rent ○ Own No. of years at this address? ______

Mailing address: ______________________ Previous address: ______________________
*if different than above *if less than 3 years

Employer: ______________ Occupation: ______________ No. years employed? ________

Insurance Information

Policy holder's name: ______________ DOB: ____________ SSN: ____________
Address (if different than above): ______________________________
Insurance Co. name: ______________ ID No. ____________ Group No.____________
Insurance Co. phone No. ____________ Claims address: ______________________
Do you have dual coverage? If yes, please continue:
Policy holder's name: ______________ DOB: ____________ SSN: ____________
Address (if different than above): ______________________________
Insurance Co. name: ______________ ID No. ____________ Group No. ____________
Insurance Co. phone No. ____________ Claims address: ______________________

Emergency Contact Information

Name: ______________ **Phone:** ______________ **Relationship to patient:** ______________

I understand that where appropriate, credit reports may be obtained.

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Patient Medical History

Physician's name: ______________________________ Approximate date of last physical exam: ______________________

Has the patient ever been under extended care of a physician? ◯ Yes ◯ No (if yes, please explain below):

____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PAITENT HAS BEEN TREATED

◯ Anemia
◯ Asthma
◯ Cold sores/Fever blisters
◯ Diabetes
◯ Depression
◯ Endocrine problems
◯ Excessive bleeding
◯ Heart problems
◯ Hepatitis
◯ HIV positive (AIDS)
◯ Nervous disorders
◯ Autism spectrum
◯ Pain in jaw joint(s)
◯ Rheumatic fever
◯ Anxiety
◯ ADD/ADHD
◯ Tuberculosis
◯ Other: ______________________

Does patient need to be medicated prior to dental appointments? ◯ Yes ◯ No (if yes, please explain):

____

Does patient gag easily? ◯ Yes ◯ No

Does patient have special needs? ◯ Yes ◯ No (if yes, please explain):

____

Does patient have frequent ear infections? ◯ Yes ◯ No

Have tonsils and adenoids been removed? ◯ Yes ◯ No

Are any medications currently being taken? ◯ Yes ◯ No (If yes, please list and explain):

____

Does patient have any allergies? ◯ Yes ◯ No (if yes, please list):

____

*foods, medications, environmental (i.e… hay fever)

Patient Dental History

General Dentist (name or name of office): __________________________ Approximate date of last cleaning: ___________

Is there any dental work to be completed? (fillings, crowns, etc.) ◯ Yes ◯ No ___________________________________
Have there been any injuries to the face, mouth, or teeth? ◯ Yes ◯ No ___________________________________
Has patient ever sucked their fingers or thumb? ◯ Yes ◯ No Until what age? _________________
Does patient have any speech problems? ◯ Yes ◯ No ___________________________________
Has patient ever had orthodontic treatment? ◯ Yes ◯ No ___________________________________
Have any family members had orthodontic treatment? ◯ Yes ◯ No ___________________________________
Is patient a mouth breather? ◯ Yes ◯ No
Have you been informed of extra or missing permanent teeth? ◯ Yes ◯ No
Is there pain in the jaw? ◯ Yes ◯ No Right, Left, or Both? _______________
Is there popping or clicking in the jaw joint(s)? ◯ Yes ◯ No Right, Left, or Both? _______________
Does patient clench or grind? ◯ Yes ◯ No
Does patient regularly have headaches? ◯ Yes ◯ No How often? ____________________

What is the chief concern that brought you to our office? ____