# Welcome! CHILD FORM

We are pleased to welcome you to our practice!
Please take a few minutes to fill out this form as completely as you can.
We look forward to helping you smile your best smile!

SAVE PRINT RESET

Name_____ Birth Date: _____
First Middle Last
Name you go by_____ Sex:☐M ☑ F Age: ____/ ____/ ____ Grade: ____/ ____/ ____

Home Address _____
Street City State Zip

Home Phone #_____Cell phone#_____
*would you like a text message reminder for appointments ?☐YES ☐NO

Email Address: _____*would you like an email reminder?☐YES ☐NO

Who may we thank for referring you_____ ♥

Interests:_____School:_____

Siblings:_____ age_____/ _____age_____/ _____age_____

Please list family members treated in our office._____

Father/Guardian_____
Address (if different)_____
Employer_____
Employer's Address_____
Soc.Sec.#_____Birthdate_____
Do you have Dental Insurance?☐ Yes /☐No **Please present card.**

Does Dad have any congenitally missing teeth? No/ Yes_____
Had past Ortho treatment? No/ Yes _____
Impacted teeth? No/ Yes_____Canine/eye teeth_____
_____

Mother/Guardian_____
Address (if different)_____
Employer_____
Employer's Address_____
Soc.Sec.#_____Birthdate_____
Do you have Dental Insurance? ☐Yes / No☐**Please present card.**

Does Mom have any congenitally missing teeth? No/ Yes_____
Had past Ortho treatment? No/ Yes _____
Impacted teeth? No/ Yes_____Canine/eye teeth_____
_____

I give permission, release and authorize:

- … Falls Orthodontics doctors and qualified staff to take diagnostic records for the purpose of planning orthodontic treatment.
- … the use of the orthodontic records for professional consultations, research, education or publication in professional journals.
- … any information from the insurance company relating to the orthodontic treatment.
- … payment to Cheryl K. Cermin, D.D.S. for the group insurance benefits otherwise payable to me.
- … I authorize Falls Orthodontics doctors to share this patient's treatment information with collaborating dentists and surgeons when appropriate.
- … I authorize Falls Orthodontics to submit treatment information pertinent to this patient to the insurance company for billing purposes only.
- … THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Signature of Parent or Guardian/Patient_____Date_____

U pdate (Initials)_____Date_____ Update (Initials)_____Date_____Update(Initials)_____Date_____

Update(Initials)_____Date_____Update(Initials)_____Date_____Update(Initials)_____Date_____

Signature of Falls Orthodontics Doctor_____Date_____

Falls Orthodontics P.O. Box 887 St. Croix Falls, WI 54024 715-483-1505

# Medical/Dental History

**General Dentist**_____ Address/City_____
Last Cleaning Appointment_____ Was there a Panoramic X-Ray taken?_____
Cavities/decay present?_____ Do you have or need an appointment scheduled for fillings/restorative? _____

Update:_____LV:_____Decay?_____ Update:_____LV:_____Decay?_____
Update:_____LV:_____Decay?_____ Update:_____LV:_____Decay?_____

***WHAT IS YOUR MAIN ORTHODONTIC CONCERN?**_____
*IS THIS A SECOND ORTHODONTIC OPINION?_____Was there a Panoramic X-Ray taken?____

**Physician** _____City/State _____
Last Well Check Appointment _____Concerns:_____
**Past or present : Specialist/Therapist**_____
Address/Clinic seen_____ City/ State_____
Date of last appointment_____ Past Treatment :_____
Future Appointments Needed? ☐No/ Yes☐ If yes, reason _____

☐Yes/ No☐ Has the patient **recently** been evaluated for orthodontics? Doctor:_____ recommended_____
☐Yes / No☐ Has the patient had orthodontic treatment? Orthodontist: _____City/State_____
Age :_____Treatment_____retainers?_____
☐Yes / No☐ Has the patient had any injury to the mouth, face, teeth or chin? Date/Year_____ Age/grade_____
Please describe_____
☐Yes / No☐ Has the patient had any noise/pain/stiffness/difficulty opening in the jaw joint? (TMJ/TMD)_first noticed_____
Right_____Left_____ Level of pain: 0 to 10_____ take pain medication?_____ Due to Accident?_____
_____
☐Yes / No☐ Does the patient snore at night?..... **Yes / No** Difficult breathing thru NOSE?..... **Yes/ No** Evaluated by an Ear Nose Throat?
☐Yes / No☐ Have tonsils been removed? Year_____Age _____.....**Yes / No** Have adenoids been removed? Year_____Age_____

☐Yes / No☐ Currently DOES the patient have a thumb habit?.....**Yes / No** Did the patient ever have a thumb habit? Age stopped:_____
☐Yes / No☐ Currently DOES the patient have a finger nail biting habit? _____

☐Yes / No☐Is the patient in any contact sports? Football/ Basketball/ Hockey/ Wrestling/ Gymnastics/ Soccer/ Baseball/ Softball/ Skiing/ Snowboarding/Boxing_____**We would like to provide a mouth guard**.

## PLEASE CIRCLE YES OR NO IF THE PATIENT HAS OR HAD ANY OF THE FOLLOWING:

YES☐ ☐NO Asthma-Medicine dependent? Y/N , allergy/exercise induced
YES☐ ☐NO Abnormal bleeding/ Hemophilia/bleeding disorder
YES☐ ☐NO MRSA: date_____
YES☐ ☐NO Hepatitis/ jaundice/ liver disease
YES☐ ☐NO Allergic reactions to _____
hives/ rash/ breathing…_____carry epi pen?_____
YES☐ ☐NO Arthritis
YES☐ ☐NO Cancer: Type_____ chemo/ radiation Date:_____
YES☐ ☐NO Congenital heart defect
YES☐ ☐NO Convulsions /epilepsy/ seizures
YES☐ ☐NO Diabetes
YES☐ ☐NO Disability/Handicap: List_____
YES☐ ☐NO Glaucoma
YES☐ ☐NO Hearing impairment_____
YES☐ ☐NO Heart murmur, Innocent? Pre medicate needed?_____
YES☐ ☐NO Autism _____
YES☐ ☐NO Currently taking any medications? Please list _____

YES☐ ☐NO AIDS/HIV
YES☐ ☐NO Ever take any diet medication(Fen-Phen)
YES☐ ☐NO Hospitalized for any reason? Date:_____
Procedure:_____
YES☐ ☐NO Blood Transfusion
YES☐ ☐NO Severe frequent headaches / Migraines
YES☐ ☐NO Cleft lip/ Palate _____
YES☐ ☐NO Joint or Bone Implants_____
YES☐ ☐NO Rheumatic fever/ Scarlet fever
YES☐ ☐NO Kidney/ Liver problems
YES☐ ☐NO Sinus problems
YES☐ ☐NO Speech problems/ speech therapy: age_____
YES☐ ☐NO Tuberculosis to_____
YES☐ ☐NO Venereal disease
YES☐ ☐NO Need ANTIBIOTICS for dental work
YES☐ ☐NO A.D.D./ A.D.H.D. diagnosed: _____

Additional medical information _____
UPDATE:
Initial_____ Date_____Changes:_____ Initial_____ Date _____Changes:_____Initial_____Date_____

Initial_____Date_____Changes:_____ Initial_____Date_____Changes:_____Initial_____Date_____