CHARTIER ORTHODONTICS

specializing in smiles for children and adults

New patient: CHILD

Today's date:

First name: Middle initial: Last name:

Address:

City: State: Zip: Home phone:

Date of birth (MM/DD/YY): / / Age: Sex: ☐ M ☐ F School: Grade:

Does the patient have any siblings? ☐ YES ☐ NO If yes, what are their ages?

Parent/guardian information

Mother's name: Employer:

Day-time phone: Cell phone: E-mail:

Father's name: Employer:

Day-time phone: Cell phone: E-mail:

Person responsible for account: Reason for orthodontic consultation:

Please list other family members seen in our office and their relation to this patient:

What is your preference for appointment reminders? ☐ phone ☐ e-mail ☐ text ☐ no reminders needed

How did you hear about our office?

Dental insurance information

Primary insurance: Group #: ID#:

Address: Phone number:

Social security number: - - Date of birth (MM/DD/YY): / /

Primary insurance policy subscriber: Employer:

Secondary insurance: Group #: ID#:

Address: Phone number:

Social security number: - - Date of birth (MM/DD/YY): / /

Secondary insurance policy subscriber: Employer:

Dental health information

Child's dentist: Address: Phone:

Is your child experiencing any dental problems? ☐ YES ☐ NO Date of last dental visit: / /

How often does your child brush per day? How often does your child floss per day?

Does your child have or has he/she had any of the following problems?

☐ YES ☐ NO tongue thrust	☐ YES ☐ NO jaw pain (joint, ear, side of face)	☐ YES ☐ NO finger or lip sucking habit
☐ YES ☐ NO sore or bleeding gums	☐ YES ☐ NO tooth sensitivity to heat, cold or sweets	☐ YES ☐ NO fear of dental work
☐ YES ☐ NO permanent tooth extraction	☐ YES ☐ NO previous orthodontic treatment	☐ YES ☐ NO missing permanent teeth
☐ YES ☐ NO difficulty chewing	☐ YES ☐ NO head/neck, jaw or tooth injury	☐ YES ☐ NO extra permanent teeth
☐ YES ☐ NO clenching or grinding	☐ YES ☐ NO clicking or popping of the jaw joints	☐ YES ☐ NO chronic mouth breather

Has your child ever had to take antibiotics prior to dental treatment? ☐ YES ☐ NO

Medical health information

Child's physician: Address: Phone:

Has your child been hospitalized for any surgical procedure or serious illness? ☐ YES ☐ NO

Does your child have or has he/she had any of the following conditions?

☐ YES ☐ NO diabetes	☐ YES ☐ NO fainting spells, seizures	☐ YES ☐ NO AIDS, HIV positive
☐ YES ☐ NO stroke	☐ YES ☐ NO rheumatic heart disease	☐ YES ☐ NO fever blisters, herpes
☐ YES ☐ NO asthma	☐ YES ☐ NO allergies (medicine or other)	☐ YES ☐ NO joint replacement or implant
☐ YES ☐ NO hepatitis	☐ YES ☐ NO latex or nickel sensitivity/allergy	☐ YES ☐ NO excessive bleeding or bruising
☐ YES ☐ NO tonsillitis	☐ YES ☐ NO high or low blood pressure	☐ YES ☐ NO drug or alcohol dependency
☐ YES ☐ NO tonsils/adenoids removed	☐ YES ☐ NO heart murmur, heart defect, heart disease	

Is the child now or has he/she ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ☐ YES ☐ NO

Does your child have any disease or problem not listed that you think we should know about? Please explain on the line below:

Is your child taking any medication at this time? ☐ YES ☐ NO If yes, please list:

I acknowledge that the above information is correct. I will notify Dr. Chartier of any changes that occur after this date.
I hereby authorize Dr. Chartier and his team to perform orthodontic evaluation/examination for my child.

☐ **check if you received a copy of our HIPAA Privacy Policy**

Parent/guardian signature: Date: