ENCINITAS ORTHODONTICS
Torin L. Chenard, DDS

CHILD PATIENT INFORMATION FORM

Welcome to our office...
Please assist us by completing the following questions...

Date of exam _____ 20____
Date of birth _____

Patient's name _____ Soc. Sec. No. _____ Age _____ Sex _____
LAST FIRST INITIAL

Res. address _____ Phone _____

School _____ Grade _____ Physician _____

Patient's dentist _____ Referred by _____

Names and ages of other children in family _____

Marital status of parents: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Person responsible for account _____ Patient lives with ☐ both parents ☐ mother ☐ father ☐ adopted

Address _____ City _____ State _____ Zip _____ Soc. Sec. Number _____

Contact E-mail address _____

Do you have an insurance plan which covers orthodontic treatment? ☐ Yes ☐ No Name of company _____

Father's name _____ Soc. Sec. No. _____ Bus. telephone _____

Employed by _____ Occupation _____

Mother's name _____ Soc. Sec. No _____ Bus. telephone _____

Employed by _____ Occupation _____

MEDICAL HISTORY

	YES	NO	?
Is the patient in good health?	☐	☐	☐
Does the patient have any history of major illness?	☐	☐	☐

Has the patient ever been treated for any of the following:

DIABETES..... ☐	BONE DISORDERS..... ☐	EPILEPSY..... ☐	PROLONGED BLEEDING..... ☐
PNEUMONIA..... ☐	HEPATITIS..... ☐	ASTHMA..... ☐	LIVER INVOLVEMENT..... ☐
HEART TROUBLE..... ☐	TUBERCULOSIS..... ☐	KIDNEY INVOLVEMENT..... ☐	FAINTING & DIZZINESS..... ☐
RHEUMATIC FEVER..... ☐	ANEMIA..... ☐	ENDOCRINE OR THYROID... ☐	NERVOUS DISORDERS..... ☐

List any drugs or medications now being taken. Give reasons. _____

Has the patient had any psychological counseling?	☐	☐	☐
List any allergies or drug sensitivity:			
Have tonsils and adenoids been removed? What age?	☐	☐	☐
Has there been significant growth within the last six months: Yes ☐ No ☐ Has patient reached puberty?	☐	☐	☐

Height: Patient's _____ Mother's _____ Father's _____ Patient most resembles: ☐ Mother ☐ Father ☐ Both

DENTAL HISTORY

	YES	NO	?
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐
Has the patient ever sucked a thumb or finger? Until what age?	☐	☐	☐
Does the patient have any speech problems?	☐	☐	☐
Has the patient had any clicking or discomfort in jaw joints near ears?	☐	☐	☐
Have you been informed of any missing or extra permanent teeth?	☐	☐	☐
Has either parent or other children had orthodontic treatment?	☐	☐	☐
Does the patient clench or grind his/her teeth?	☐	☐	☐
Does the patient want orthodontic treatment?	☐	☐	☐
When did the patient last visit his/her dentist? Were any x-rays taken?	☐	☐	☐
Does the patient have any congenital abnormalities:	☐	☐	☐

Has the patient had a previous orthodontic examination? Yes ☐ No ☐ If so, how long ago? _____

List sports and interests: _____

Reason for today's visit: _____

How did you hear about our office? _____

_____
Signature

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