full smile
ORTHODONTICS

WELCOME

STEVE ASTUTO, DDS

PATIENT #_____

Tell us about your child

PATIENT'S NAME

DATE OF BIRTH | AGE

SOCIAL SECURITY #

NICKNAME ○ MALE ○ FEMALE

HOBBIES SCHOOL

PHYSICAL ADDRESS

CITY | STATE | ZIP

MAILING ADDRESS

CITY | STATE | ZIP

HOME PHONE | CONTACT EMAIL

OTHER FAMILY MEMBERS SEEN BY US

PLEASE ADD REASON FOR VISIT

Parent 1 information

○ MARRIED ○ SINGLE ○ GUARDIAN ○ STEP-PARENT ○ FOSTER PARENT

NAME

SOCIAL SECURITY #

DATE OF BIRTH

EMPLOYER | WORK PHONE

HOME PHONE | ALT. PHONE

DRIVER'S LICENSE | EXPIRATION

Parent 2 information

○ MARRIED ○ SINGLE ○ GUARDIAN ○ STEP-PARENT ○ FOSTER PARENT

NAME

SOCIAL SECURITY #

DATE OF BIRTH

EMPLOYER | WORK PHONE

HOME PHONE | ALT. PHONE

DRIVER'S LICENSE | EXPIRATION

Who is accompanying the child today?

NAME

RELATIONSHIP TO CHILD

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ○ YES ○ NO

In case of emergency, please call

NAME

PHONE

NAME AND PHONE # OF NEAREST RELATIVE NOT LIVING WITH YOU

Insurance information

INSURED'S NAME

INSURED'S DATE OF BIRTH

INSURED'S SOCIAL SECURITY # | MEMBER ID#

RELATIONSHIP TO PATIENT

EMPLOYER

EMPLOYER'S ADDRESS

EMPLOYER'S PHONE

INSURANCE CO. NAME

INSURANCE CO. ADDRESS | STATE | ZIP

INSURANCE CO. PHONE

GROUP (PLAN, LOCAL OR POLICY)

SIGNATURE OF PARENT / GUARDIAN

X

DATE

Whom may we thank for referring you?

NAME

○ PATIENT ○ DOCTOR ○ OTHER

ADDRESS

PHONE

Dental and Medical History

NAME OF CHILD'S GENERAL DENTIST?

DATE OF LAST DENTAL VISIT?

FOR WHAT SERVICE?

HAS YOUR CHILD HAD ANY INJURIES TO MOUTH, TEETH, OR HEAD?

HAS YOUR CHILD HAD AN UNHAPPY DENTAL EXPERIENCE?

CHILD'S PEDIATRICIAN

PHONE # | DATE OF LAST VISIT

IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN?

○ YES ○ NO

PLEASE DESCRIBE YOUR CHILD'S CURRENT PHYSICAL HEALTH:

○ GOOD ○ FAIR ○ POOR

PLEASE LIST ALL DRUGS AND FOODS THAT THE CHILD IS ALLERGIC TO AND TYPE OF REACTION

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS THAT THE CHILD IS CURRENTLY TAKING:

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

YES	NO	
○	○	THUMB / FINGER SUCKING
○	○	LIP SUCKING / BITING
○	○	NAIL BITING
○	○	NURSING / BOTTLE / SIPPY CUP
○	○	MOUTH BREATHING
○	○	NIGHTTIME GRINDING OF TEETH

DOES YOUR CHILD HAVE A HEART CONDITION? (SUCH AS A HEART MURMUR)

○ YES ○ NO

IF YES, EXPLAIN

IF YES, CHILD'S CARDIOLOGIST'S NAME

PHONE#

Health History

DOES THE CHILD HAVE / OR EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

YES	NO	
○	○	CANCER / TUMORS
○	○	DIABETES
○	○	RHEUMATIC FEVER
○	○	HIV+ / AIDS
○	○	HEMOPHILIA
○	○	ASTHMA
○	○	HEPATITIS
○	○	TUBERCULOSIS (TB)
○	○	CHRONIC UPPER / RESPIRATORY PROBLEMS
○	○	CONVULSION / EPILEPSY
○	○	ABNORMAL BLEEDING
○	○	HEARING IMPAIRMENT
○	○	VISION PROBLEMS
○	○	ANY OPERATIONS '(PLEASE EXPLAIN BELOW)
○	○	ANY HOSPITAL STAYS '(PLEASE EXPLAIN BELOW)
○	○	KIDNEY / LIVER PROBLEMS
○	○	HANDICAPS / DISABILITIES
○	○	ALLERGIES
○	○	PEANUT ALLERGY
○	○	PREGNANT
○	○	SMOKER
○	○	ADD&ADHD
○	○	DEVELOPMENTALLY DELAYED
○	○	AUTISM
○	○	DOWNS SYNDROME
○	○	SPEECH PROBLEMS

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT YOUR CHILD HAS/HAD:

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I ALSO AUTHORIZE THE DOCTORS AND THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES MY CHILD MAY NEED. THE RESPONSIBLE PARTY IS THE PARENT WHO BRINGS THE CHILD TO THE DENTAL OFFICE, INDEPENDENT OF WHAT A DIVORCE DECREE MAY STATE. REIMBURSEMENT MUST BE MADE BETWEEN THE DIVORCED PARTIES. WE WILL NOT INTERVENE.

SIGNATURE OF PARENT / GUARDIAN

X

DATE

SIGNATURE OF PERSON ACCOMPANYING CHILD

X

DATE

Thank you for letting us be an important part of your child's dental health.