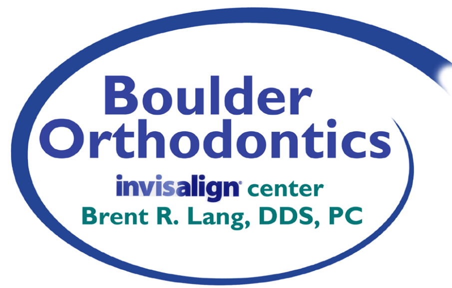


**We would like to welcome you and your family to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.**

## Tell Us About Your Child

**Today's Date:** ________________________________

**Male** **Female**

**Child's Name:** ________________________________
Last First MI

***Nickname:***________________________________

**Child's Birthdate:**____/____/____**Child's Age:** ____

**School:**________________________________

**Hobbies and Sports:**________________________________

________________________________

________________________________

**Child's Home # (___)**________________________________

**E-Mail**________________________________

**Fax #(___)**________________________________

**Child's Home Address:**________________________________

________________________________

________________________________

________________________________

## Whom May We Thank For Referring You?

**Whom may we thank for referring you?**

________________________________

**General Dentist:** ________________________________

**List brothers/sisters with ages:**________________________________

________________________________

________________________________

________________________________

## Mother's Information

**Mother's Information:** **Step Mother** **Guardian**

**Name:**________________________________

**Occupation:**________________________________

**Wk #(___)**________________________________

**Hm #(___)**________________________________

**E-Mail** ________________________________

## Father's Information

**Father's Information:** **Step Father** **Guardian**

**Name:**________________________________

**Occupation:**________________________________

**Wk #(___)**________________________________

**Hm #(___)**________________________________

**E-Mail**________________________________

## Appointments

**Who is responsible for making appointments?**

________________________________

**Daytime #(___)**________________________________

**Hm#(___)**________________________________

1900 Folsom Suite 211 Telephone 303.449.3250
Boulder, CO 80302 www.boulderorthodontics.com

**What are the main concerns that you would like orthodontics to accomplish?** ________________
________________________________________
________________________________________
________________________________________

Has your child been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth, or chin? Yes No

List any musical instruments played: __________
________________________________________

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: ________________________

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 that your child is currently taking: ________________________________
________________________________________

Please list all drugs/things that your child is allergic to: ____________________________
________________________________________
________________________________________

**Has your child ever had any of the following medical problems?**

| | |
|---|---|
| Y N Abdominal bleeding | Y N Diabetes |
| Y N Allergies to any drugs | Y N Handicaps/Disabilities |
| Y N Allergies to latex/metals | Y N Hearing Impairment |
| Y N Allergic to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hepatitis |
| Y N Any Operations | Y N Hemophilia |
| Y N Asthma | Y N HIV+/AIDS |
| Y N Cancer | Y N Kidney/Liver Problems |
| Y N Congenital Heart Defect | Y N Rhuematic/Scarlet Fever |
| Y N Convulsions/Epilepsy | Y N Tuberculosis |

**Please discuss any medical problems that your child has had:** ____________________________
________________________________________
________________________________________
________________________________________
________________________________________

**Does/did your child have any of the following habits?**

| | |
|---|---|
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking/Biting | Y N Speech Problems |
| Y N Mouth Breathing | Y N Thumb/Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

**Neighbor or Relative not living with you:**

Name ________________________________

Phone ________________________________

Address ______________________________
________________________________________
________________________________________

I understand that the information 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 authorize the dental staff to perform the necessary dental services my child may need.

**Signature of parent or guardian** ________________________________________Date ________________

This office reserves the right to verify the credit status of potential patients and/or parents of the patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

**Signature of parent or guardian** ________________________________________ Date ________________