crowcanyonorthodontics

Welcome to Crow Canyon Orthodontics

TELL US ABOUT YOUR CHILD

Today's Date: _____

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/_____ Age: _____ Social Security # _____-____-_____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone # _____

School:_____ Grade:_____ Hobbies: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY

Name: _____ Relation:_____ Do you have legal custody of this child? ☐Yes ☐No

Please list brothers/sisters with ages: _____

Who may we thank for referring you? _____ General Dentist:_____ Date of last visit?_____

Parent's Marital Status: ☐Single ☐Married ☐Divorced ☐Partnered ☐Separated ☐Widowed

PARENT'S INFORMATION

Name:_____ Birthdate:_____ Social Security #_____

Employer:_____ How long at current job?_____ Occupation: _____

Home Phone #_____ Work Phone #_____

Name:_____ Birthdate:_____ Social Security #_____

Employer:_____ How long at current job?_____ Occupation: _____

Home Phone #_____ Work Phone #_____

INSURANCE INFORMATION

Primary

Subscriber's Name: _____ Birthdate: ___/___/_____ Subscriber's SSN: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Phone # _____ Group #_____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employer: _____

Secondary

Subscriber's Name: _____ Birthdate: ___/___/_____ Subscriber's SSN: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Phone # _____ Group #_____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employer: _____

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DENTAL AND MEDICAL HISTORY

What treatment goals would you like to accomplish? _____

Has your child ever been evaluated by an Orthodontist? □Yes □No

Has your child ever experienced any TMJ Pain? □Yes □No

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

Has your child ever injured his/her mouth, chin, or teeth? □Yes □No

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

Does your child floss his/her teeth daily? □Yes □No

Has your child ever taken Phen-Fen?

Has your child ever taken Fosomax or any other bisphosphonate?

Have adenoids or tonsils been removed?

Is your child currently under the care of a Physician? □Yes □No If yes, please explain:_____

Physician's name: _____ Phone #_____ Date of last visit:_____

Is your child currently taking any medication? □Yes □No Please list each one: _____

Is your child allergic to: □Latex □Plastics/Metals □Aspirin □Penicillin? □Other: _____

Has your child ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Hepatitis
Y N ADD/ADHD	Y N Convulsions/ Epilepsy	Y N HIV+/AIDS
Y N Any Hospital Stays	Y N Diabetes	Y N Kidney/Liver problems
Y N Any Operations	Y N Handicaps/ Disabilities	Y N Rheumatic/ Scarlet Fever
Y N Artificial Bones/Joints	Y N Hearing Impairment	Y N Sickle Cell Disease/Traits
Y N Asthma/Difficulty breathing	Y N Heart Murmur	Y N Sinus Problems
Y N Cancer	Y N Hemophilia	Y N Tuberculosis

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

Y N Clenching/ Grinding Teeth	Y N Nail Biting	Y N Finger/ Thumb sucking
Y N Lip sucking/ biting	Y N Nursing Bottle Habit	Y N Tongue Thrusting
Y N Mouth Breathing	Y N Speech Problems	

I affirm that the information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform this office of any changes in medical status.

Signature_____ Date: _____