Rarrick Orthodontics
Orthodontic Specialist

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Patient Information

Today's Date: _____/_____/_____ Full Name: _____ Nickname: _____

Child's Birthdate: ____/____/_____ Age: _____ SS#: _____ ☐Male ☐Female

School: _____ Grade: _____ Hobbies/Sports: _____

Child's Home Address: _____

General Information

Who is accompanying the child today? Name: _____ Relation: _____

Do you have legal custody of this child? ☐Yes ☐No Other siblings: _____

General Dentist: _____ Dentist's Phone #: _____

Last Visit: _____ Whom may we thank for referring you? _____

In the event of an emergency, is there a relative or friend who lives near you that we should contact?

Name: _____ Phone #: _____

Address: _____

Parent's Information

Who is responsible for the account? _____

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

☐**Father** ☐Mother ☐Step Father ☐Step Mother ☐Guardian

Name: _____ Birthdate: ____/____/____ SS#: _____

Address (If different than child's): _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Home #:_____

☐**Mother** ☐Father ☐Step Mother ☐Step Father ☐Guardian

Name: _____ Birthdate: ____/____/____ SS#: _____

Address (If different than child's): _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Home #: _____

Orthodontic Insurance Information

Primary Insurance Co. Name: _____ Phone #: _____

Secondary Insurance Co. Name: _____ Phone #: _____

Member American Association of Orthodontists

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish? _____

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

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

Does the child require antibiotics before dental treatment? ☐Yes ☐No

Have adenoids or tonsils been removed? ☐Yes ☐No

Does your child have any missing or extra permanent teeth? ☐Yes ☐No

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

Does the child brush his/her teeth daily? ☐Yes ☐No Floss his/her teeth daily? ☐Yes ☐No

Has puberty begun? ☐Yes ☐No Has menstruation begun? ☐Yes ☐No

Please describe the child's current physical health: ☐Good ☐Fair ☐Poor

Physician: _____ Phone #: _____ Date of Last Visit:_____

Please list all drugs that the child is currently taking: _____

Is your child allergic to: **Latex** ☐Yes ☐No **Nickel/Metals** ☐Yes ☐No **Plastic** ☐Yes ☐No

Aside from the items listed above, list all drugs/things your child is allergic to: _____

_____

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	ADD/ADHD	Y	N	AIDS/HIV+
Y	N	Any Hospital Stays/Operations	Y	N	Asperger Syndrome	Y	N	Asthma
Y	N	Artificial Bones/Joints/Valves	Y	N	Autism	Y	N	Cancer
Y	N	Congenital Heart Defect	Y	N	Convulsions	Y	N	Covid-19
Y	N	Diabetes	Y	N	Epilepsy	Y	N	Hearing Impairment
Y	N	Handicaps/Disabilities	Y	N	Heart Murmur	Y	N	Hemophilia
Y	N	Hepatitis	Y	N	Kidney Problems	Y	N	Liver Problems
Y	N	Mitral Valve Prolapse	Y	N	Prosthetics	Y	N	Rheumatic Fever
Y	N	Sickle Cell Disease/Traits	Y	N	Tuberculosis (TB)	Y	N	Scarlet Fever

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐Yes ☐No

Are the child's immunizations current? ☐Yes ☐No

Is there anything you would like to discuss with the Doctor in private? ☐Yes ☐No

Please discuss any serious medical problems the child has had: _____

Does/did the child experience any of the following?

Y	N	Clenching/Grinding teeth	Y	N	Breast Fed	Y	N	Lip Sucking/Biting
Y	N	Mouth Breather	Y	N	Nail Biting	Y	N	Speech Problems
Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust	Y	N	Used Pacifier
Y	N	Thumb/Finger Sucking						

I understand that the information I have given is correct and to the best of my knowledge, that it will be held in the strictest confidence and that 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 orthodontic services my child may need.

Parent Signature: _____ Date: _____

OFFICE USE ONLY: *I have verbally reviewed the medical/dental information above with the patient named herein.*

Signature/Initials of Reviewer: _____ Date: _____