CHILD FORM

Dr.	
Recs.	Date / Time
X-Ray	Date / Time

SANTA CLARITA ORTHODONTICS

Dr. Anthony Cha, D.D.S., M.S.

ORTHODONTICS and DENTOFACIAL ORTHOPEDICS

1ST EXAM	Month	Day	YR
RE-CALL	Month	Day	YR
RE-CALL	Month	Day	YR

1 Tell Us About Your Child

Child's Name: ______ (Last) ______ (First) ______ (Middle) ____ Male / ____ Female

Prefers to be called: ______ Birthdate: ______ Age: ______

Address: ______ (Address) ______ (City) ______ (Zip) Home Phone: ______

School: ______ Grade: ______ Hobbies: ______

List brothers / sisters with their age: ______

Family in treatment with us: ______ Whom may we Thank for referring you? ______

2

General Dentist: ______ Last Visit Date: ______

Address: ______ Phone #: ______

3 Mother's Information

Responsible Party ___ Yes / ___ No

Name: ______ __ Step Mother __ Guardian Birthdate: ______

Work # ______ Home # ______

Employer: ______ Job Title: ______

How long at current job: ______ SS#: ______ DL#: ______

4 Father's Information

Responsible Party ___ Yes / ___ No

Name: ______ __ Step Father __ Guardian Birthdate: ______

Work # ______ Home # ______

Employer: ______ Job Title: ______

How long at current job: ______ SS#: ______ DL#: ______

5 Parent's Marital Status

___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

Person (Not living with you) to contact in case of emergency

Name: ______ Relationship: ______ Phone #: ______

6 Primary Orthodontic Insurance

Insurance Co. Name: ______

Policy Owners Name: ______

Policy Owners Birthdate: ______

Policy Owners SS#: ______

7 Secondary Orthodontic Insurance

Insurance Co. Name: ______

Policy Owners Name: ______

Policy Owners Birthdate: ______

Policy Owners SS#: ______

Creating a Better World One Smile at a Time!

CHILD

Dental History

Any injuries to head or mouth? ______ Any jaw clicking, locking or pain? ______

Has child ever had Orthodontic Treatment or worn a "Retainer" or Bite Plate? ______

What is your main concern: ______

Has child ever had any previous unhappy dental visits? ______

Has either parent had Ortho Treatment: Who: ______ When: ______

Please check any of the following conditions that apply:

- [ ] Baby Teeth Removed
- [ ] Chipped / Injured Teeth
- [ ] Cyst Infection
- [ ] Dental Treatment in Progress
- [ ] Difficulty Breathing / Chewing
- [ ] Food Impaction
- [ ] Frequent Cold Sores, Canker Sores
- [ ] Grinding Teeth or Clenching
- [ ] Jaw Fractures, Pain, Clicking
- [ ] Missing Teeth
- [ ] Mouth Breathing
- [ ] Periodontal Problems, Bleeding Gums
- [ ] Root Canals
- [ ] Sensitivity to Cold / Hot
- [ ] Teeth Irritating Cheek / Lips
- [ ] Thumb Habit To age: ______
- [ ] Tongue Habit
- [ ] Any Permanent or Extra Teeth Removed

Medical History

Physician ______ Phone # ______ Last visit: ______

Please list all medications your child is currently taking: ______

Does your child need to be Pre-Medicated? ______ Why: ______

Allergies: ______ Medical Insurance: ______
Food / Medication / Latex Gloves / Unknown

Has your child ever been hospitalized? ______ Explain: ______

Please check any of the following conditions that apply:

- [ ] Accidents
- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Artificial Joints
- [ ] Asthma or Hay Fever
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Bruises Easily
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chemotherapy
- [ ] Is Your Child in Good Health [ ] Yes [ ] No
- [ ] Circulatory Problems
- [ ] Diabetes / Blood Sugar
- [ ] Epilepsy
- [ ] Fainting – Seizures – Convulsions
- [ ] Glandular / Hormonal Problems
- [ ] Glaucoma
- [ ] Headaches - Severe
- [ ] Hearing Loss
- [ ] Heart Murmur
- [ ] Heart Problems

  Describe ______
- [ ] Hemophilia
- [ ] Hepatitis / Jaundice
- [ ] High or Low Blood Pressure
- [ ] HIV Positive / AIDS
- [ ] Immunizations
- [ ] Jaw Pain
- [ ] Kidney or Bladder
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Nervous Problems
- [ ] Polio / Mono / Pneumonia
- [ ] Pneumonia
- [ ] Prolonged Bleeding
- [ ] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Severe Infections
- [ ] Shortness of Breath
- [ ] Speech or Learning Disorder
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Venereal Disease

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

It is my responsibility to advise the office of any changes in Personal/Medical status: **Parent's Initial** ______

Are there any Psychological or Emotional Problems that should be brought to our attention: ______

Please sign that this information is accurate and complete:

Signature ______ Relationship ______ Date

Received By Dr. ______ Date ______

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? **Yes / No**