QuestOrthodontics
smiles accomplished

Welcome To Our Practice

CHILD PATIENT INFORMATION

Name First: ____________________Last:________________________ Age ___________ Birthdate __________

Nickname ___________________________________ ☐ Male ☐ Female

Address____________________________________ City/State ________________________ Zip ___________

Home Phone # _______________________ Cell Phone # __________________________

Parent/Guardian Name ____

School Attending ______________________________ Hobbies ____

Siblings in treatment with Quest Orthodontics ____

Has patient had previous orthodontic consultations? ☐Yes ☐ No Previous orthodontic treatment? ☐Yes ☐ No

If so, when/where? ____________________________________ Doctor's name ______________________________

What is it about your teeth/bite/smile that has brought you to see us? _______________________________________

Who may we thank for referring you to Quest Orthodontics ? ____

RESPONSIBLE PARTY INFORMATION

Name ____________________________________ Relation to Patient ____________ Marital Status S / M / W / D

Address _____________________________________ City/State ____________________ Zip ________________

Cell Phone _______________________ Cell Carrier _____________________ Work Phone __________________

Email Address ____

How would you like to receive your Appointment Reminders? ☐ Text Message ☐ Email ☐ Both

Social Security # _______ - _____ - ________ Birthdate ____________________

Employer _____________________________________ Occupation ______________________________________

Second Parent Name _________________________________ Relationship to Patient _________________________

Social Security # _______ - _____ - ________ Birthdate ____________________

Phone # ______________________________ Work Phone # _____________________________

Employer _____________________________________ Occupation ______________________________________

Name of nearest relative not living with you ____

Contact # ___________________________________ Work # ____

Address _____________________________________ City/State _________________________ Zip ___________

DENTAL INFORMATION

Patient's Dentist ____ Patient's Last Dental Visit _________________________

Has patient had any unfavorable dental experiences? ____

Does the patient currently have, or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Thumb / Finger Sucking	☐	☐	Nail Biting	☐	☐	Missing permanent teeth not due to extraction
☐	☐	Lip Sucking / Lip biting	☐	☐	Nursing/Bottle Habits	☐	☐	Periodontal Disease

MEDICAL INFORMATION

Patient's Overall Health ☐ Excellent ☐ Good ☐ Poor

Is patient currently under the care of a doctor? ☐ Yes ☐ No. If yes, what for _______________________________________

Is patient currently taking any medication? ☐ Yes ☐ No. If yes, what for? ____

Has patient ever been hospitalized? ☐ Yes ☐ No. If yes, what for? ____

Does the patient currently have, or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Def	☐	☐	Prosthesis	☐	☐	Scarlet Fever Hx
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy	☐	☐	Asthma	☐	☐	Kidney/Liver Problem
☐	☐	Diabetes	☐	☐	Abnormal Bleeding	☐	☐	Hepatitis	☐	☐	Handicap/Disabilities
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment	☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	HIV / AIDS	☐	☐	Any Operations	☐	☐	Tuberculosis	☐	☐	Allergy to Any Drugs

Please discuss any serious medical conditions the patient has/had ____

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I understand 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.

___________________________ ________________________________ __________________

Print Parent/Guardian Name Parent/Guardian Signature Date

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

____________________________________ ________________________________

Signature Date

____

Doctor's Comments