Hodges Orthodontics

101 North Davis St.
Sulphur Springs, TX 75482
903-885-2800

CHILD PATIENT INFORMATION

Today's Date: _____
Name: _____ Prefers to be called: _____ Sex:_____
Age: _____ Date of Birth: _____ Phone Number: _____
Patients Interests: _____
Patient resides with : Mother Father Both Other: _____
Address: _____ City:_____State:_____ Zip:_____
Patient's Dentist: _____ School:_____ Grade:_____
Describe your child's orthodontic problem: _____
Has any member of the family had orthodontic treatment? If so, by whom: _____
Please list names of other family members treated in our office _____
Whom may we thank for referring you to our office? _____
Who is accompanying the patient today? _____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: Married Separated Divorced Widowed

	FATHER	**MOTHER**
Name:	_____	_____
Date of Birth:	_____	_____
Address: (if different than above)	_____	_____
Phone: (if different than above)	_____	_____
E-mail Address:	_____	_____
Employer's Name:	_____	_____
Occupation:	_____	_____

Person responsible for account: _____

If other than parent:

Name: _____Address: _____ Phone: _____

In case of an emergency, please provide name, address, and phone number of your nearest relative:

Name: _____Address: _____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of Policyholder: _____
Date of Birth: _____ Social Security #: _____-_____-_____
Insurance carrier company: _____

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Physician's Name: _____Address:_____Phone:_____

Has your child experienced any health problems? No Yes Explain:_____
Any major change in your child's health recently? No Yes Explain:_____
Is your child currently under a physician's care? No Yes Explain:_____
Is your child allergic to any medications? No Yes Explain:_____
Has your child received a blood transfusion? No Yes Explain:_____
Have your child's tonsils or adenoids been removed? No Yes Explain:_____

Please check if your child has had any of the following conditions:

Heart Murmur……..	No	Yes	Hepatitis……..	No	Yes	Emotional Problems….	No	Yes
Heart Surgery……..	No	Yes	Diabetes……..	No	Yes	Frequent Headaches..	No	Yes
Rheumatic Fever…….	No	Yes	Kidney Disease..	No	Yes	Nervous/Anxious……..	No	Yes
Endocrine disorders……	No	Yes	Liver Disease…..	No	Yes	Cancer……..	No	Yes
Prolonged Bleeding…….	No	Yes	Tuberculosis……	No	Yes	Bone Disorders……	No	Yes
Anemia ……..	No	Yes	Bronchitis…….	No	Yes	Growth Disorders…….	No	Yes
Blood Disease……..	No	Yes	Asthma…….	No	Yes	Mouth Breather……	No	Yes
Developmental Disorder..	No	Yes	Epilepsy……	No	Yes	Herpes(Fever Blisters)..	No	Yes
Hives/Rash……	No	Yes	Fainting…….	No	Yes	Tonsillitis……..	No	Yes

Has the patient ever had an unusual reaction to any drug such as penicillin, antibiotics, or aspirin? No Yes
If so, please explain: _____
Is there any other condition or problem that you think we should know about? _____

Growth Information for Patients:

Because growth can be a factor in orthodontic treatment planning, your answers to the following questions are needed to aid in selection of treatment alternatives.

Has your son or daughter reached puberty? No Yes
Girls- has she started menstruation? No Yes When?_____
Boys- has his voice changed? No Yes When?_____
Father's Height: _____ Mother's Height: _____ Patient Adopted? No Yes
Names and birthdates of patients brothers and sisters: _____
Dental checkups: 2 times a year 1 time a year Only if problem exists Never Date of last visit: _____
Is there any unfinished care to be completed with your child's dentist? No Yes Explain:_____
Is your child frightened about dental treatment? No Yes Explain:_____
Has your child had an unpleasant experience in a dental office? No Yes Explain:_____
Have teeth (either primary or permanent) been removed? No Yes Explain:_____
Has your child had any previous orthodontic treatment/consult? No Yes Explain:_____
Are you satisfied with prior treatment? No Yes Explain:_____
Any changes in your child's bite or dental alignment recently? No Yes Explain:_____
Does your child have a history of thumb or finger sucking? No Yes Explain:_____
Does your child play a musical instrument? No Yes Explain:_____
Has your child had any facial or dental injuries? No Yes Explain:_____

Please check if there is a history of:

Clenching Teeth _____ Muscular soreness around head and neck _____ Jaw joint soreness _____
Grinding Teeth _____ Headaches (more than normal) _____ Jaw Joint clicking _____
Speech Problems (if so what sounds) _____ Mouth breathing _____ Ringing in the ears_____
Snoring _____ Is there any other information which may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

_____ _____ _____
Parent Signature **Date** **Reviewed by**