BRACES 2000
Orthodontics For Children and Adults

1863 Alum Rock Ave, Suite
San Jose, CA 95116
408-937-4757

WELCOME

To Our Orthodontic Office !

Please fill out this form for your Child as completely as possible prior to your Initial Orthodontic Examination Appointment.

ABOUT YOUR CHILD

Today's Date _____

Child's Name _____ ☐ Male ☐ Female

He/She prefers to be called _____ Birthdate _____ Age _____

School _____ Grade _____ Hobbies _____

Whom may we **Thank** for referring your child to our office ? _____

Other family members seen by us _____

Is your child concerned about the appearance and health of his/her teeth? _____

Does your child want his/her teeth straightened? _____

Who will be financially responsible for your child's treatment ? _____

PARENT'S INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Divorced or Separated, who has primary custody? ☐ Mother ☐ Father

Father's Name _____ Please Circle: Mr. Dr.

Home Address _____ Apt. # _____
Street Address

_____ Years At This Address _____
City *State* *Zip Code*

Employer _____ Years Employed _____ Occupation _____

Home # _____ Work # _____ Ext _____

Soc. Sec. # _____ Driver's License # _____ Birthdate _____

Mother's Name _____ Please Circle: Mrs. Ms. Dr.

Home Address _____ Apt. # _____
Street Address

_____ Years At This Address _____
City *State* *Zip Code*

Employer _____ Years Employed _____ Occupation _____

Home # _____ Work # _____ Ext _____

Soc. Sec. # _____ Driver's License # _____ Birthdate _____

ORTHODONTIC INSURANCE

Is Orthodontic Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Is Secondary or Dual Insurance Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Please Complete Back of Form

Medical Information

Physician's Name _____ Date of Last Medical Exam _____
Address _____ Phone # _____
If currently under a Physician's care, for what reason? _____
If taking any medications, please list: _____
Is your child allergic to any medications? _____ Latex allergy?_____
Are any medications required prior to dental work? _____

Does Your Child Have Or Has He/She Ever Had Any Of The Following?

☐ Heart Disease	☐ Ulcers	☐ Epilepsy	☐ Allergies
☐ Abnormal Blood Pressure	☐ Tuberculosis / Lung Disease	☐ Frequent Headaches	☐ Sinus Trouble
☐ Rheumatic Fever	☐ Venereal Disease	☐ Nervous Disorders	☐ Hay Fever
☐ Asthma	☐ Hepatitis / Liver Problems	☐ Cancer or Leukemia	☐ Hearing Disability
☐ Arthritis	☐ Glaucoma	☐ Radiation Therapy	☐ Communication Disorder
☐ Bleeding Problems	☐ Diabetes	☐ H.I.V. Positive	☐ Learning Disorder
☐ Anemia	☐ Herpes	☐ Bone Disorders	☐ Growth Disorders

If Yes, please explain_____
Does your child's growth rate appear to be: ☐ Slow ☐ Average ☐ Fast
Father's Height _____ Mother's Height _____ Is this child adopted? ☐ Yes ☐ No
Female Patients: Has menstrual cycle started? ☐ Yes ☐ No At what age? _____
Male Patients: Has voice changed? ☐ Yes ☐ No At what age? _____

Dental Information

Current Dentist's Name _____ City _____ Date of Last Visit _____
Date of Last X-Rays _____ Type _____ Any Current Dental Pain? _____

Has Your Child Ever Had Or Does He/She Experience Any Of The Following?

☐ Teeth Sensitive to Hot, Cold, Sweets or Pressure	☐ Clicking or Popping of Jaw Joint	☐ Pain, Swelling, or Bleeding of Gums
☐ Traumatic Injury to Teeth or Mouth	☐ Clenching or Grinding of Teeth	☐ Loosening of Permanent Teeth
☐ Pain or Tenderness Around Ear, Joint or Side of Face	☐ Periodontal Treatment	Oral Habits: ☐ Thumb or Finger Sucking
Difficulty in: ☐ Opening / Closing ☐ Chewing	☐ TMJ / Splint Treatment	☐ Lip / Cheek Biting ☐ Nail Biting
☐ Swallowing ☐ Speaking	☐ Ulcers / Cold Sores	☐ Mouth Breathing ☐ Tongue Thrust

If Yes, please explain _____
Has your child ever had an upsetting experience in the dental office? _____

Orthodontic Information

What is your primary concern about your child's teeth? _____
How would you like us to correct the problem? _____
Do you have any concerns about orthodontic treatment? _____
Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____
Please describe _____
Have other family members had Orthodontic treatment? _____ Orthodontist _____
Please describe _____
Is there any additional information you would like us to know? _____

Please bring this completed form to your Initial Orthodontic Appointment. We look forward to meeting you and your child!

Signed _____ Date _____ Reviewed by _____

The Information Provided Above May Be Used To Obtain Insurance Confirmation and/or A Credit Report