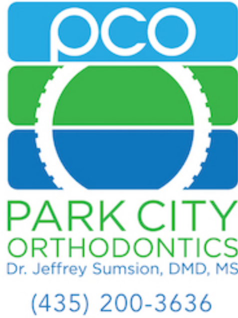

WELCOME TO PARK CITY ORTHODONTICS

We are excited to see you for your first visit to our office. We promise to make it a fun and enjoyable experience.

Please confirm the correctness of the completed information and fill in the empty fields as completely as possible.

Please Tell Us About Your Child:

Today's Date: ________________________________

Name: ________________________________

Nickname: ________________________________

Birth Date: ________________________________

Home #: ________________________________

Cell #: ________________________________

Home Address: ____________________________

City ____________________ State_____ Zip______

Email: ________________________________

Work #:________________________________

Who is accompanying your child today?

Name:_____________ Relation:________________

Do you have legal custody of this child? **Y** **N**

Whom may we thank for referring you?

Their name?:________________________________

List child's siblings (name/age):

General Dentist's Name:______________________

Last Dental Visit (date):______________________

Parents Marital Status:_______________________

Responsible Party's Information:

Relationship to patient?______________________

Name: ________________________________

Employer:________________________________

Job Title:________________________________

Work Phone#:_____________________________

Cell Phone #:_____________________________

Time at current job?__________________________

SS#________________________________

Birthdate:________________________________

Address (if different):________________________

Email address: ____________________________

Spouse's Information:

Relationship to patient?______________________

Name: ________________________________

Employer:________________________________

Job Title:________________________________

Work Phone#:_____________________________

Cell Phone #:_____________________________

Time at current job?__________________________

SS#________________________________

Birthdate:________________________________

Address (if different):________________________

Email address: ____________________________

Primary Orthodontic Insurance:

Insurance Co. Name__________________________

Address:________________________________

Phone: ________________________________

Policy Owner's Name:_________________________

Relationship to patient: ______________________

Group # (plan or policy#: ____________________

Policy Owners Birthdate:______________________

SS#: ________________________________

Policy Owners Employer:______________________

Secondary Orthodontic Insurance:

Insurance Co. Name__________________________

Address:________________________________

Phone: ________________________________

Policy Owner's Name:_________________________

Relationship to patient: ______________________

Group # (plan or policy#: ____________________

Policy Owners Birthdate:______________________

SS#: ________________________________

Policy Owners Employer:______________________

Medical History

What is your main orthodontic concern regarding your child?________________________________

____

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

Have adenoids or tonsils been removed? ________ yes ________ no

Has your child been informed of any missing or extra permanent teeth ________ yes ________ no

Does your child brush their teeth daily? ________ yes ________ no

Does your child floss their teeth daily? ________ yes ________ no

Is your child under the care of a physician ________ yes ________ no

Please describe your child's current physical health: ____ Good ____ Fair ____ Poor

List any musical instruments played by your child:________________________________

Please list all drugs that your child is currently taking:____________________________

Please list all drugs to which your child is allergic:______________________________

Has your child ever had any of the following medical problems? (circle yes or no)

Y	N	Abnormal bleeding	Y	N	Diabetes
Y	N	Allergies to any drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Does/did your child exhibit any of the following habits?

Y	N	Clenching/ Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breathing	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrusting

If you answered yes to any of the above, please explain:____________________________

____

I understand that 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.

________________________________ ________________________

Signature of Parent or Guardian Date