



Child Patient Information

Date: _____
Child's Name: _____ Likes to be called: _____
Child's School: _____ Sports/Hobbies: _____
Birthdate: ____/____/____ Age: _____ Sex: Male Female
Address: _____
Street City State Zip
Parent or guardian name: _____ Phone: _____
How did you hear about us? _____
Reason for the visit today? _____

Responsible Party Information

Name: _____
Residence: _____
Street City
State Zip
Mailing Address: _____
Street City
State Zip
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Social Security #: _____ Birthday: _____ Relationship to Patient: _____
Employer: _____ City: _____ State: _____
Occupation: _____
Spouse's Name: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____
Occupation: _____

Dental Insurance Information

Insured's Name: _____ Insured's Social Security #: _____
Insurance Company: _____ Group No. _____ Local No. _____
Insurance Co. Address: _____ Phone No. _____
Do you have dual coverage? Yes ___ No ___ If yes:
Insured's Name: _____ Insured's Social Security #: _____
Insurance Company: _____ Group No. _____ Local No. _____
Insurance Co. Address: _____ Phone No. _____

I understand that insurance claims will be submitted by Dr. Fodero's office. I understand that I am responsible for all charges not paid to Dr. Fodero by my insurance. I authorize release of any information relating to this claim to the insurance carrier.

Signature: _____ Date: _____

Emergency Information

Name of nearest relative not living with you: _____

Complete Address: _____ Phone: _____

Street City Zip

Medical History

Physician: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Circle any of the medical conditions below for which your child has been treated:

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Tuberculosis |
| Bone Disorders | Heart Problems | Kidney Problems | Tumor or Cancer |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | |

Any other special problems not listed above? _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____

Yes No Is the patient allergic to any medication? _____

Yes No Is the patient allergic to latex? _____

Yes No Has the patient reached puberty (menstruation, voice changes, facial hair)? _____

Dental History

General Dentist: _____ Date of Last Visit: _____

Address: _____

Street City State Zip

What specific concerns do you have regarding your patient's teeth? _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Has the patient ever had a bad experience at the dentist? _____

Yes No Does the patient require antibiotics before teeth cleaning or other dental appointments? _____

Yes No Does the patient have any speech problems? _____

Yes No Does the patient breath through his/her mouth? _____

Yes No Does the patient have frequent sore throats/tonsillitis? _____

Yes No Has the patient received treatment from an allergist or ear, nose and throat specialist? _____

Yes No Any injuries to teeth, mouth, or jaws? _____

Yes No Does your patient's lower jaw ever click or get sore? _____

Yes No Does the patient have trouble opening wide? _____

Yes No Does your child grind or clench his or her teeth? _____

Yes No Has the patient ever been informed of having any missing or extra permanent teeth? _____

Yes No Has the patient every lost or chipped any teeth? _____

Yes No Any type of thumb/finger or tongue habit? _____

Yes No Has the patient ever seen an orthodontist? If yes who and when? _____

Yes No What is the patient's attitude about orthodontic treatment? _____

Yes No Does the patient need extra help with instructions? _____

Yes No Does the patient gag during dental procedures? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Have any other family members received orthodontic treatment? _____

