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Welcome to our practice. The benefits of a happy, healthy, beautiful smile are immeasurable! Please fill out this form completely. The better we communicate, the better we can care for your child.

Patient Information

Today's Date: _____
Child's Name (First, M.I., Last): _____ Preferred Name:_____ Male / Female
Birthdate: _____ Age: _____
School: _____ Grade: _____
Hobbies/Sports/Musical instruments played: _____
Patient lives with whom / relationship? _____ Who has legal custody of patient? _____
Child's home telephone: _____ Cell phone: _____
Home address: _____
Name of sibling & ages: _____
What concerns you about your child's smile / bite? _____
Has your child ever been evaluated or had orthodontic treatment before? Y / N If so, with whom? _____
Have we treated any other family members? Y / N If so, what are their names? _____
Name / relationship of person accompanying patient to today's appointment: _____
Whom may we thank you for referring you? _____

Your Child's Medical / Dental History

Child's Physician: _____
Phone number of physician: _____ Date of last visit: _____
Has your child been hospitalized for any reason? Y / N If yes, please explain:_____
Please list any medications your child is taking (including non-prescription): _____
Please list any allergies to medicines/foods/substances (for example: latex/metals/plastics): _____
Has your child ever taken IV or oral bisphosphonates for bone disorders or cancer? Y / N
Does your child use tobacco? Y / N
For female patients only: Has menstruation begun? Y / N If yes, when? _____ Is your child pregnant or possibly could be? Y / N

Please check all that may apply for your child—presently or in the past.

Arthritis	Y / N	Heart trouble (artificial valve, congenital heart defect, murmur)	Y / N
Artificial joints / implants	Y / N		
Asthma	Y / N	Hepatitis	Y / N
Birth defects	Y / N	HIV / AIDS	Y / N
Cancer	Y / N	Rheumatic / Scarlet Fever	Y / N
Diabetes	Y / N	Tonsils / Adenoids removed	Y / N
Epilepsy / fainting / seizures	Y / N	Hearing impairment	Y / N
Excessive bleeding / Anemia / Other Blood Disorder	Y / N	Sinus problems	Y / N
Headaches	Y / N	Thyroid problems	Y / N
Hereditary problems	Y / N		

Are there any other medical / behavioral / physical conditions? _____

Does your child pre-medicate with antibiotics for dental procedures? Y / N

Child's Dentist: _____ Date of last cleaning: _____
Was any dental treatment recommended that needs to be completed? _____
Have there been any injuries to the face/mouth/teeth/chin? Y / N Please explain: _____
Are you aware of any missing / extra permanent teeth? Y / N
Does your child have any oral habits (thumb/finger/tongue/lip sucking, nail biting, grinding/clenching, tongue thrust)? Y / N
If yes, please explain: _____
Has your child had speech therapy? Y / N Please explain: _____
Has your child experienced any jaw joint discomfort? Y / N Popping / clicking? Y / N
Does your child brush his/her teeth adequately? Y / N
Does your child floss daily? Y / N

Responsible Party / Parent Information

Mother's Information:

Parent ___ Guardian ___ Stepmother ___

Name: _____
Birthdate: _____
Address: _____
Email address: _____
Cell phone: _____
Work phone w/ ext: _____
Employer / Occupation: _____
How long at current job: _____

Father's Information:

Parent ___ Guardian ___ Stepfather ___

Name: _____
Birthdate: _____
Address: _____
Email address: _____
Cell phone: _____
Work phone w/ ext: _____
Employer / Occupation: _____
How long at current job: _____

Primary Insurance Information

Insurance Company: _____ Insurance Phone Number: _____
Employer / Group Name: _____ Group number: _____
Subscriber / Employee: _____ Subscriber ID: _____
Social Security Number: _____ Date of Birth: _____ Relationship to patient: _____

Secondary Insurance Information

Insurance Company: _____ Insurance Phone Number: _____
Employer / Group Name: _____ Group number: _____
Subscriber / Employee: _____ Subscriber ID: _____
Social Security Number: _____ Date of Birth: _____ Relationship to patient: _____

Emergency Contact Information (Other than responsible party):

Name: _____ Relationship to patient: _____
Cell phone: _____ Home phone: _____ Work phone: _____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status.

I understand the office of Dr. Deborah Sema may use my health information for treatment, billing, and healthcare operations. I have been given a copy of the Notice of Privacy Practices to read and know that I may obtain my own copy if desired.

Our office reserves the right to verify the credit status of potential patients and/or parents of patients.

_____ _____
Signature of parent / guardian **Date**