



PATIENT INFORMATION – CHILD

PATIENT NAME: _____

SEX ASSIGNED AT BIRTH:

GENDER IDENTITY:

MALE FEMALE

MALE FEMALE NON-BINARY SPECIFY _____

PREFERRED PRONOUNS: HE/HIM/HIS

SHE/HER/HERS

THEY/THEM/THEIRS

BIRTHDATE: (mm/dd/yyyy) ____/____/____

AGE: _____

ADDRESS: _____

MOTHERS NAME: _____

EMAIL: _____

WORK PHONE: _____

CELL PHONE: _____

FATHERS NAME: _____

EMAIL: _____

WORK PHONE: _____

CELL PHONE: _____

IF PARENTS ARE SEPARATED/DIVORCED, WHO IS THE PRIMARY PARENT MAKING HEALTH CARE DECISIONS FOR YOUR CHILD?

MOM

DAD

BOTH

N/A

FOR VIRTUAL APPOINTMENTS:

iPhone (Facetime) – Cell: _____

Zoom

DENTISTS NAME: _____

REFERRAL SOURCE: _____

DENTAL INSURANCE: (Is this your policy? If no, please add the policy holders name and birthdate)

YES

NO

POLICY HOLDER NAME: _____

BIRTHDATE: _____

INSURANCE COMPANY	POLICY NUMBER	CERTIFICATE

****PLEASE NOTE****

- REGULAR VISITS TO YOUR DENTIST MUST CONTINUE DURING YOUR ORTHODONTIC TREATMENT
- SOME APPOINTMENTS WILL INFRINGE UPON SCHOOL OR WORK HOURS

MAIN REASON/CONCERN FOR ORTHODONTIC CONSULTATION: _____



HAVE YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- | | | | |
|-------------------------|--|--------------------|--|
| Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chronic Kidney Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Lung Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Prolonged Bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |

DO YOU HAVE ANY ALLERGIES? YES NO - If yes, to what? _____

DO YOU HAVE ANY CONDITION THAT COULD AFFECT YOUR IMMUNE SYSTEM? YES NO
(e.g. HIV, AIDS, LEUKEMIA) If yes, please describe your condition:

DO YOU HAVE ANY MEDICAL CONCERNS? IF YES, PLEASE LIST THEM BELOW: YES NO

- _____
- _____
- _____

DO YOU TAKE ANY MEDICATION? IF YSE, PLEASE LIST THEM BELOW: YES NO

- _____
- _____
- _____

WHEN WAS YOUR LAST DENTAL CHECK UP AND CLEANING: _____

DO YOU HAVE ANY OF THE FOLLOWING HABITS:

- | | | | |
|-------------------------|--|-----------------|--|
| THUMB/SOOTHER SUCKING | <input type="checkbox"/> YES <input type="checkbox"/> NO | NAIL BITING | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| GRINDING TEETH AT NIGHT | <input type="checkbox"/> YES <input type="checkbox"/> NO | MOUTH BREATHING | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| SNORING | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

HAS ANY MEMBER OF THE FAMILY HAD ANY ORTHODONTIC TREATMENT? YES NO

HAVE YOU HAD ANY PREVIOUS ORTHODONTIC CONSULTATIONS OR TREATMENT? YES NO

DO YOU PLAY ANY MUSICAL INSTRUMENTS? YES NO - IF YES, WHAT? _____

I give permission to allow Dr. D. Sonya to report to my dentist or any other dental professional as they deem necessary. I also give permission for any records made in the process of examination, treatment and retention to be used for purposes of research, education or publication in professional journals. - initials _____

Signature: _____ Date: _____



Sea to Sky Smiles
— ORTHODONTIC CENTRE —

Dr. Dorothy A. Sonya
Certified Specialist in Orthodontics