WELCOME

To The Orthodontic Office of Dr. James Meeks

CHILD'S INFORMATION

Male____ Female____ Today's Date_____

Child's Name _____ Birthdate _____ Age ____
First Last

Address _____
Street City Zip

School _____ Grade _____ Hobbies _____

Names and ages of siblings _____

Who may we thank for referring you to our office? _____

PARENT'S INFORMATION

Marital Status _____

Mother's Name _____ Birth date _____

Occupation _____ Employer _____

Phone_____ Email _____

Father's Name _____ Birth date _____

Occupation _____ Employer _____

Phone_____ Email_____

Person(s) Responsible for Account _____

DENTAL INSURANCE INFORMATION

Name of Insured (Who has the insurance)? _____

Birth date_____ Social Security Number_____

Insurance Company Name _____

Insurance Company Phone _____ ID Number _____

Please provide us with a copy of your dental insurance card. If you have coverage with more than one insurance company, please copy both insurance cards. Thank you!

MEDICAL AND DENTAL HISTORY

Child's Dentist _____ City _____ Phone _____
Child's Physician _____ City _____ Phone _____

Has your child had any major illness, surgery, medical problems? ___ Yes ___ No
List (if applicable) _____

List any medications child is currently taking _____

List any medications your child is allergic to _____

List any other allergies (latex gloves, metals, etc.) _____

Is your child currently in good health? ___ Yes ___ No

Does your child require antibiotics prior to having routine dental treatment? ___ Yes ___ No

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	HIV+ / AIDS
Y	N	Diabetes	Y	N	Kidney / Liver Problems
Y	N	Blood Transfusion	Y	N	Tuberculosis (TB)
Y	N	Hepatitis	Y	N	Asthma
Y	N	Rheumatic / Scarlet Fever	Y	N	Bone Disorders
Y	N	Heart Defect / Murmur	Y	N	Nervous Disorders
Y	N	Cancer	Y	N	Epilepsy / Convulsions

Have there been any injuries to your child's face, mouth, teeth, or chin? ___ Yes ___ No
Are you aware of any missing permanent teeth? ___ Yes ___ No
Has your child had any jaw joint (TMJ) symptoms or problems? ___ Yes ___ No
Has any previous orthodontic treatment been done for your child? ___ Yes ___ No

Does your child have any of the following habits?

Y	N	Thumb / Finger Sucking	Y	N	Grinding / Clenching Teeth
Y	N	Tongue Thrusting	Y	N	Mouth Breather
Y	N	Speech Problems	Y	N	Lip Sucking / Biting

Is there a specific problem or reason for your visit today? _____
_____
_____

_____
Parent's Signature