Center for Early Orthodontic Treatment

WELCOME!

Thank you for choosing our Center for your child's orthodontic care!

PATIENT INFORMATION

Patient's Name:_____ **Nickname:**_____ **DOB:**_____ **Gender:** ☐ M ☐ F

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary number for appointment confirmations: (____) ____ - _____ **School / Daycare:**_____

Do you realize that most Orthodontic appointments are during school hours? ☐ Yes ☐ No

Other children in the family? ☐ Yes ☐ No **Their ages:**_____

PARENT INFORMATION

Mother's Name:_____

DOB:_____ **SS#:**_____

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home: (____) ____ - _____ **Cell:** (____) ____ - _____

Email:_____

☐*Check box if Address is same as patient's listed above*

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Employer:_____ **Position:**_____

Work: (____) ____ - _____

Father's Name:_____

DOB:_____ **SS#:**_____

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home: (____) ____ - _____ **Cell:** (____) ____ - _____

Email:_____

☐*Check box if Address is same as patient's listed above*

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Employer:_____ **Position:**_____

Work: (____) ____ - _____

Who does the patient live with? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Name of nearby relative or friend:_____ **Relationship to patient:**_____

Home: (____) ____ - _____ **Cell:** (____) ____ - _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured:_____

DOB:_____ **SS#:**_____

Employer: _____

Phone: (____) ____ - _____

Insurance Co.:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: (____) ____ - _____

Group/Policy #:_____

I.D.#:_____

SECONDARY COVERAGE

Name of Insured:_____

DOB:_____ **SS#:**_____

Employer:_____

Phone: (____) ____ - _____

Insurance Co.:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: (____) ____ - _____

Group/Policy #:_____

I.D.#:_____

HOW DID YOU HEAR ABOUT US?

☐ **Sibling(s)**:_____
☐ **Friend**:_____
☐ **Pediatrician / Physician**:_____
☐ **Dentist**:_____
☐ **School / Daycare**:_____
☐ **Insurance**:_____
☐ **Other**:_____
☐ **Drive by** ☐ **Website** ☐ **Facebook** ☐ **Google**

DENTAL HISTORY

Dentist / Pediatric Dentist:_____ **Phone:** (____) ____ - _____ **Date of Last Exam:**_____

Main concerns you would like Orthodontics to address?_____

Has either parent had orthodontic treatment? ☐Yes ☐ No **Family members with similar orthodontic condition:**_____

Please check all that applies to your child:

☐ Any injuries to the head or neck area
☐ Any injuries to the mouth or teeth
☐ Snores when sleeping
☐ Breathes through mouth more than nose
☐ Frequent colds, sore throats, or ear infections
☐ Headaches
☐ Pain and / or clicking in jaw joint
☐ Jaw has ever "locked" open or closed
☐ Grinds or clenches teeth
☐ Adult teeth came in behind baby teeth
☐ Teeth removed by a Dentist
☐ Difficulty chewing and / or swallowing
☐ Noisy / Sloppy eating
☐ Speech problems
☐ Sucking habits (thumb, finger, lip, etc.)
☐ Biting/Chewing habits (tongue, cheek, nails)
☐ Delivered Naturally / C- Section
☐ Bottlefed / Breastfed
☐ Pacifier / Sippy cup use
☐ Previous orthodontic evaluation
☐ Previous orthodontic treatment
☐ Unusual dental experience
Please specify: _____

MEDICAL HISTORY

Child's Physician:_____ **Phone:** (____) ____ - _____ **Date of Last Exam:**_____

History of Hospitalizations / Surgeries / Recent Illnesses (Explain):_____

_____

Current Medications:_____

Has patient received treatment from an allergist or ear, nose, and throat (ENT) specialist? ☐ Yes ☐ No **If Yes, when?**_____

Has patient had tonsils and/or adenoids removed? ☐ Yes ☐ No **If Yes, when?** _____

Has your child ever been diagnosed and/or treated for any of the following conditions? (Check all that apply)

☐ Blood Disorder / Anemia
☐ Abnormal Bleeding / Hemophilia
☐ Immune Disorder / HIV/ AIDS
☐ Cancer / Tumor / Leukemia
☐ Heart Murmur / Defect / Surgery
☐ Rheumatic Fever
☐ High / Low Blood Pressure
☐ Epilepsy / Seizures / Convulsions
☐ Kidney Problems
☐ Liver Disease / Jaundice / Hepatitis
☐ Diabetes
☐ Stomach / GI Disorder / GERD
☐ Tuberculosis (TB)
☐ Asthma / Reactive Airway
☐ Tonsillitis
☐ Sinus Infection
☐ Cold Sores
☐ Congenital Birth Defects
☐ Premature / Low Birth Weight
☐ Cleft Lip / Palate
☐ Autism Spectrum
☐ ADD / ADHD
☐ Eating Disorder
☐ Vision Problems
☐ Hearing Problems
☐ Mental / Cognitive / Social Delay

ALLERGIES:

☐ Drugs:_____
☐ Dairy Products ☐ Metal/Plastic
☐ Wheat/Cereal ☐ Latex
☐ Food Dyes ☐ Dust, Pollen
☐Other _____

Special interests and hobbies:_____

I affirm that the above information is true and correct to the best of my knowledge. I hereby, give my permission to Dr. Pinskaya to communicate with other healthcare professionals regarding treatment recommended.

Parent's Signature:_____ **Date:**_____

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