FLUSHING ORTHODONTICS

5255 W. Pierson Road, Flushing, MI 48433
(810) 733-6605

Tell Us About Your Child

Today's Date: ____/____/____ Preferred Name:_____

Child's Name_____
LAST FIRST MI

Birthdate: _____/_____/____ Age:_____ □ Male □ Female

School:_____Hobbies:_____

Address:_____

_____
CITY STATE ZIP

Home Phone:_____

Cell Phone:_____

Email:_____

General Information

Who is accompanying child today?

_____

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?

_____

Other siblings/ages: _____

_____

Preferred appointment reminder method:

□ Email _____

□ Text #_____

Parent's Information

□ Father □ Stepfather □ Guardian

Marital Status: S M D W Birthdate: _____/_____/_____

Name:_____

Address: (If different than child's)

_____

_____

Hm Phone:_____Cell:_____

Work Phone:_____ SSN:_____

Employer:_____

Email:_____

Insurance Co. Name:_____

Insured's ID #:_____ Group #:_____

Ins. Phone:_____

□ Mother □ Stepmother □ Guardian

Marital Status: S M D W Birthdate: _____/_____/_____

Name:_____

Address: (If different than child's)

_____

_____

Hm Phone:_____Cell:_____

Work Phone:_____ SSN:_____

Employer:_____

Email:_____

Insurance Co. Name:_____

Insured's ID #:_____ Group #:_____

Ins. Phone:_____

(PLEASE COMPLETE BACK OF FORM)

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Dental and Medical History

General Dentist:_____ Phone:_____

Address:_____

Last cleaning:____/____/____ Has patient ever been evaluated for or had orthodontic treatment before: Y / N

Child's Interest in treatment: □ Excited □ Willing □ Reluctant

Does/did the patient have the following habits? Grind teeth Y / N Finger/Thumb sucking Y / N

Have □ Tonsils □ Adenoids been removed? □ No

Has the patient experienced any unfavorable reaction from any previous dental or medical care? Y / N

Does patient require antibiotics before dental procedures? Y / N

If yes, please specify and give reason for this need: _____

Does the patient brush teeth: □ Often □ Occasionally □ Reluctantly

Family Physician:_____ Phone:_____

Address:_____

Is patient currently under a physician's care? Y / N If yes, explain: _____

Is patient taking any medicine at this time? Y / N Please specify: _____

Is patient allergic to any medication? Y / N Please specify: _____

Does patient have any known allergies? Y / N Please specify: _____

Has the patient been hospitalized or had any surgeries?? Y / N Please specify:_____

Does the patient have any history of these (Circle all that apply)?:

Yes / No Allergies	Yes / No Lung Disorder	Yes / No Heart Disorder/Murmur	Yes / No Speech Difficulties
Yes / No Anemia	Yes / No Breathing difficulties	Yes / No Hypertension	Yes / No Emotional Disorders
Yes / No Prolonged bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Congenital Heart Disease	Yes / No Hearing difficulties
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Rheumatic fever	
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Endocrine/Hormone disorders	
Yes / No Artificial Joint	Yes / No Neurologic disorder	Yes / No Diabetes	
Yes / No AIDS or HIV	Yes / No Cerebral palsy	Yes / No Hepatitis or Liver Disorder	
Yes / No ADD/ADHD	Yes / No Convulsions/ Seizures	Yes / No Kidney or bladder Disorder	

If patient is experiencing or has a history of any disease, condition or problem not addressed, please explain:

_____

Signature:_____ **Date**: _____

Relationship to patient: _____