



**WELCOME:** Thank you for seeking an orthodontic evaluation for your child. Please fill out this form completely (both sides) and ask us for help if you have any questions.

### About Your Child

PATIENT'S NAME (Last, First, Middle Initial)		PREFERRED NAME / NICKNAME		TODAY'S DATE / /	
STREET ADDRESS					
CITY			STATE	ZIP	HOME PHONE ( )
BIRTH DATE / /	AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SCHOOL		GRADE
PLEASE LIST ANY SPORTS, HOBBIES, MUSICAL INSTRUMENTS AND AFTER SCHOOL EVENTS YOUR CHILD IS INVOLVED IN:					

### Parents or Guardians

FAMILY STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
FATHER	EMPLOYER	DAY-TIME PHONE ( )
MOTHER	EMPLOYER	DAY-TIME PHONE ( )
How did you hear about Dr. Ekim?		
EMAIL ADDRESS		

### Medical Health Information

Is your child under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has there been any change in your child's general health within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME OF YOUR CHILD'S PHYSICIAN	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE NUMBER ( )
Does your child have or have they had any of the following diseases or problems?		
Scarlet Fever, Rheumatic Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (medicine or other) <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defect, Heart Murmur, Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma, Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
High or Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding or Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug or Alcohol Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS, HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes, Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any disease, condition, diagnosis or problem not listed that you think I should know about? Please explain:		
Is your child taking any medication at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:		

## Dental Insurance Information

PRIMARY INSURANCE COMPANY NAME		COMPANY ADDRESS		GROUP / PLAN NUMBER	
PRIMARY POLICY HOLDER'S NAME			SOCIAL SECURITY NUMBER - -		DATE OF BIRTH / /
SECONDARY INSURANCE COMPANY NAME		COMPANY ADDRESS		GROUP / PLAN NUMBER	
SECONDARY POLICY HOLDER'S NAME			SOCIAL SECURITY NUMBER - -		DATE OF BIRTH / /
<p>The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.</p>					
Authorized Signature of Covered Person/Employee			Authorized Signature of Covered Person/Employee		
Date			Date		

## Dental Health Information

Is your child experiencing any dental problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF LAST DENTAL VISIT / /	How often does your child brush and floss each day? Brushes _____ times per day      Flosses _____ times per day	
FAMILY DENTIST	DENTIST'S ADDRESS	DENTIST'S PHONE NUMBER (      )	
Does your child have or have they had any of the following diseases or problems?			
Tooth Sensitivity to Heat, Cold or Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore or Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head, Neck or Jaw Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Permanent Tooth Extraction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis of TMJ or TMD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Orthodontic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fear of Dental Work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or Popping of the Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching or Grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw Pain (Joint, Ear, Side of Face)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Finger or Lip Sucking Habit	<input type="checkbox"/> Yes <input type="checkbox"/> No