CULVER CITY ORTHODONTICS
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Orthodontic Patient Intake Form – Child

Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Preferred Pronouns *(optional)*: _____

Primary Phone #: _____ Primary Email: _____

Address: _____ City: _____ State: ____ Zip: _____

School: _____ Grade: _____ Hobbies/Interests/Sports: _____

Sibling(s) Name(s) and Age(s): _____

Responsible Party/Parent/Legal Guardian Information

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Age: _____ Sex: _____ Preferred Pronouns: _____

Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Age: _____ Sex: _____ Preferred Pronouns: _____

Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____

Dental Insurance Information

Insured Name: _____ Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Insurance Member ID: _____ Group #: _____

Insurance Company Address: _____

Phone: _____ Insured's Employer: _____

(If you have dual coverage, complete section below)

Insured Name: _____ Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Insurance Member ID: _____ Group #: _____

Insurance Company Address: _____

Phone: _____ Insured's Employer: _____

Medical History Information

Which best describes your child's general health? *(Circle one)* Excellent Good Fair Poor

Last Dental Visit *(date and reason for visit):* _____

Name/phone # of patient's regular dental provider: _____

Name/phone # of patient's physician: _____

Does the patient have a history with any of the following systemic conditions? *(Circle one for each)*

1) Heart/Cardiovascular conditions Yes No
(e.g. High blood pressure, stroke, heart defect, artificial valve, pacemaker, heart attack)
If "Yes," please explain:

2) Lung/Respiratory conditions Yes No
(e.g. Asthma, emphysema, chronic bronchitis)
If "Yes," please explain:

3) Bleeding Disorders Yes No
4) Immune Deficiency or HIV Yes No
If "Yes," please explain:

5) Autoimmune Disease Yes No
(Rheumatoid Arthritis, Lupus, etc.)
6) Cancer/Radiation/Chemotherapy Yes No
7) Organ Transplant Yes No
8) Diabetes Yes No

9) Liver Disease Yes No
10) Renal Dialysis/Kidney Disease Yes No
11) Arthritis/Painful Joints Yes No
12) Artificial Joints Yes No
13) Osteoporosis Yes No
14) Seizures/Epilepsy Yes No
15) Numbness/Tingling/Paralysis Yes No
16) Muscle Weakness/MS Yes No
17) Depression/Anxiety Yes No
18) ADD/ADHD Yes No
19) Cognitive Impairments Yes No
If "Yes," please explain:

20) Other Psychiatric Conditions Yes No
If "Yes," please explain:

21) Other medical conditions? Yes No
If "Yes," please explain:

Has your child ever been hospitalized? ..... Yes No
If "Yes," please explain:

Does your child require antibiotic prophylaxis before dental treatment? ..... Yes No

Has your child ever taken intravenous bisphosphonate medication, such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)? ..... Yes No

Has your child ever taken oral bisophosphonate medication, such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)? ..... Yes No

Is your child currently pregnant or breastfeeding? ..... Yes No

(If Female child/adolescent) Has menstruation begun? ..... Yes No
If "Yes," when: _____

Do you have any of the following allergies?

Penicillin	Yes	No	Latex	Yes	No	Other:	Yes	No
Sulfa Drugs	Yes	No	Nickel/Metals	Yes	No	*(Please specify)*		

Please list all current medications: _____

_____

Orthodontic Specific Questions

What are your personal goals for orthodontic treatment and what, if anything, would you like to change about your/your child's smile or appearance?

What specific questions/concerns do you want to make sure the doctor addresses today?

Have you/your child had any previous orthodontic treatment?..... Yes No
If "Yes," please explain: _____

Have you/your child been to another orthodontist for a consultation?..... Yes No
If "Yes," please explain: _____

Are you comfortable with us discussing our orthodontic plan in front of your child?..... Yes No
If "No," please explain: _____

Have you/your child had negative experiences in a dental office in the past?..... Yes No
If "Yes," please explain: _____

Does your child have any sensory issues/gag reflex we should be aware of?..... Yes No
If "Yes," please explain: _____

Have you/your child had any injury to the head, neck, jaws, or teeth?..... Yes No
If "Yes" please explain: _____

Do you/your child have jaw pain or difficulty opening/closing your jaw?..... Yes No

Do you/your child have recurrent poor sleep, snoring, daytime sleepiness?..... Yes No
(If "Yes") Have you ever been diagnosed with Obstructive Sleep Apnea?..... Yes No

Do you/your child have a history of any pacifier/finger sucking habits past the age of 6?..... Yes No

Do you have a history of orthodontic problems in your family (e.g. underbite, crossbite)?..... Yes No
If "Yes," please explain: _____

Is there any history of craniofacial anomalies (cleft lip, cleft palate, etc.) in your family?..... Yes No
If "Yes," please explain: _____

Patient/Guardian Signature:_____ **Date:**_____

(If Patient is a minor) Relationship to Patient:_____