Welcome to the office of Dr. Petras

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: (_____) _____

Child's Home Address: _____

_____

Who does your child reside with? _____

2 Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Who is responsible for making appointments?

_____

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Does your child need to be pre-medicated before dental visits? ☐ **Yes** ☐ **No**

Last Visit Date: _____

3 Parent / Guardian Information

Parent's Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

PLEASE PROVIDE BOTH PARENTS' CONTACT INFORMATION IF SEPARATED OR DIVORCED.

Person Responsible for Account:

Name: _____ Relation: _____

Address: _____ Phone #: _____

Employer: _____ Address: _____ Phone #: _____

Name: _____ Relation: _____

Address: _____ Phone #: _____

Employer: _____ Address: _____ Phone #: _____

4 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

S.S. # _____

Group # (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

5 Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

S.S. # _____

Group # (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

6 What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

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

Please discuss any medical problems or allergies that your child has had.

_____

_____

_____

_____

☐ Yes ☐ No	Abnormal Bleeding	☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Allergies to any Drugs	☐ Yes ☐ No	Handicaps/Disabilities
☐ Yes ☐ No	Allergic to Latex / Metals	☐ Yes ☐ No	Hearing Impairment
☐ Yes ☐ No	Allergic to Plastic	☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Any Hospital Stays	☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Any Operations	☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	HIV + / AIDS
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Kidney / Liver Problems
☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No	Rheumatic / Scarlet Fever
☐ Yes ☐ No	Convulsions / Epilepsy	☐ Yes ☐ No	Tuberculosis (TB)

8 Does/did your child have any of the following habits?

☐ Yes ☐ No	Clenching / Grinding Teeth	☐ Yes ☐ No	Nursing Bottle Habits
☐ Yes ☐ No	Lip Sucking / Biting	☐ Yes ☐ No	Speech Problems
☐ Yes ☐ No	Mouth Breather	☐ Yes ☐ No	Thumb / Finger Sucking
☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No	Tongue Thrust

9 Please Read, Sign & Date Below

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Parent or Guardian _____ Date _____

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.