

Today's Date___/__/

Child's height :_____

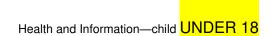
Health and Information—child UNDER 18

Biological mother's height:_____

OVER>>>

NAME	Prefers to be called	Birth date/E	3irth Sex Age_
Child's Hm. Address	City	Zip Child's Hm. ph	none
Child lives with: Both parents Mother	_Father Other	School	Grade
E-mail (to confirm appts)			
Favorite School Subjects	What is the o	quality of their school work? AE	3CDF_
Hobbies/Sports/Musical Instruments			
Please list brothers/sisters with age:			
Has anyone in the family had braces / Invisali			
Who is accompanying your child today?			
Whom may we thank for referring you?			
How often does your child see the dentist?			
now often does your child see the deflist?		Date of last defital exam(MMM/	TT)/
What are the main concerns that you would	d like orthodontics to add	ress?	
Has your child been evaluated for or had orthogonal	odontic treatment? When? _	/ Where?	Y N
Is your child self-conscious of his/he			Y N
Have there been any injuries to the f		on a contact to a the O	Y N Y N
Have you been informed that he/she Has your child ever had any pain/ten			Y N Y N
Does your child have any dental prol			Y N
Does he/she have to be reminded to	brush the teeth daily?		Y N
Any significant events or anything e		treating your child?	Y N
Please explain any 'Y' answers above			
Airway: Please circle if: adenoids	/ tonsils / or both / have bee	n removed? When?/	Y N
Do they snore when sleeping? If so,	please circle one. Nightly	/ Frequently / Occasionally	Y N
Does your child have or	have they had any of the	following tendencies or habits	s?
Lips apart/mouth breathe -Awake	Y N V	Vake up often in the night	Y N
	Y N T	humb/finger suck or tongue thrust	
		Speech concerns or therapy	Y N
		Smoke, vape or chew tobacco	Y N
Move around/restless during sleep	Y N F	ear of dental visits	Y N
Please explain any 'Y' answers above			
	MEDICAL INFORMATION	Child's Physician:	
Did/does your child have: Ever have to be hospitalized	Y N S	Substance abuse problem	Y N
		Psychiatric counseling	Y N
	Y N F	requent or severe headaches	Y N
		Epilepsy / seizures	Y N
		Sensory or anxiety concerns	Y N
,		ip or inside mouth lesions (sores)	
9		atex, vinyl, or acrylic allergy Nickel or other metal allergy	Y N Y N
		Penicillin or other allergy	
Please explain any 'Y' answers or list any		•	-
Some medications can affect tooth movem the medication was prescribed:	nent. Please list any medica	tions your child is taking and the co	ondition for which
Growth, maturation and genetic tendencies orthodontic treatment. The following inform Has your child:(If male) had voice changes?	s play an important role in nation is requested to assist	determining the most opportune us in evaluating jaw/overall growth	potential:

Biological father's height:_____





Today's Date___/__/ Specialist in Orthodontics

PATIENT'S NAME		Child Health History and Information (page 2)	
Mother's Name		_ Biological □ Adoptive □ Stepmother □ Guardian □	
ddressPhone			
Employer	_ Work Phone _	Cell Phone	
Father's Name		_ Biological □ Adoptive □ Stepfather □ Guardian □	
Address	Phone		
Employer	_Work Phone	Cell Phone	
Patient's biological parents: ☐ Married ☐ Divorced ☐ Mot	her remarried □ F	ather remarried Separated Widowed (N/A if patient adopted)	
PERSON RESPONSIBLE FOR MAKING APPOINTMEN	NTS:		
	IT OF THE ACC	ODONTIC TREATMENT TO SIGN THE FINANCIAL COUNT. ANY ARRANGEMENTS FOR A THIRD PARTY RESPONSIBLE PARTY AND THE THIRD PARTY.	
PRIMARY ORTHODONTIC INSURANCE: IF YOU WI		OUR OFFICE SUBMIT YOUR INSURANCE, PLEASE	
Insurance Co. Name			
Insurance Co. Address			
Insurance Co.Phone #Gro	oup #	Social Security #	
Insured's Name		Relation	
Insured's employer		Insured's birthdate	
SECONDARY ORTHODONTIC INSURANCE:			
Insurance Co. Name			
Insurance Co. Address			
Insurance Co.Phone #Gro	oup #	Social Security #	
Insured's Name		Relation	
Insured's employer		Insured's birthdate	
I authorize the release of information relating to orthodont claims. I understand that I am responsible for all costs of t		eby authorize payment directly to F. Richard Beckwith, DDS rance benefits otherwise payable to me.	
X	X		
Signed (Patient, or parent if minor) Date	Sig	ned (insured person) Date	

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