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*We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and enjoyable.*

## 1. Tell Us About Your Child

Today's Date

Child's Name

☐☐

Name Preferred

Male

Female

Child's Birth date

Child's Age

School

Grade

Child's Home #

Child's Home Address

City, State, Zip

## 2. Who is Accompanying the Child Today

Name

Relation

Do you have legal custody of this child?

Yes ☐

No ☐

Other family members seen by us

Relationship

## 3. Mother's Information

☐ Birth Mother

☐ Step Mother

☐ Adoptive

☐ Guardian

Name

Work Ph.

Home Ph.

Employer

How Long

Occupation

SS#

Email address

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

## 4. Father's Information

☐ Birth Father

☐ Step Father

☐ Adoptive

☐ Guardian

Name

Work Ph.

Home Ph.

Employer

How Long

Occupation

SS#

Email address

☐ Married

☐ Divorced

☐ Separated

☐ Single

☐ Widowed

## 5. Person Responsible for Account

Name

Relation

Billing Address

City, State, Zip

Work Ph.

Home Ph.

Employer

DL No.

SS#

Date of Birth

## 6. Primary Dental Insurance

Insurance Co. Name

Insurance Co. Phone No.

Insured's Name

Relationship to Patient

Insured's Birth date

SS#

Insured's Employer

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

Yes/No

- ☐ ☐ Heart Murmur  
☐ ☐ Cancer  
☐ ☐ Diabetes  
☐ ☐ Rheumatic Fever  
☐ ☐ HIV+/AIDS  
☐ ☐ Hemophilia  
☐ ☐ Asthma  
☐ ☐ Hepatitis

Yes/No

- ☐ ☐ Tuberculosis (TB)  
☐ ☐ Congenital Heart Defect  
☐ ☐ Convulsions/Epilepsy  
☐ ☐ Hearing Impairment  
☐ ☐ Endocrine Problems  
☐ ☐ Kidney/Liver Problems  
☐ ☐ Handicaps/Disabilities

Please discuss any serious medical problems that the child has had:

Allergic to latex: ☐ Yes ☐ No

Medications the child is currently taking:

Medications the child is allergic to

## 8. Dental History

Why did you bring the child to the orthodontist today?

Present/Previous Dentist

Date of Last Visit

Has the child ever had any of the following:

Yes/No

- ☐ ☐ Serious/difficult problem associated with previous dental work?  
☐ ☐ Tonsils or adenoids removed?  
☐ ☐ Pain/tenderness in their jaw joint  
☐ ☐ Thumb or finger sucking

Who may we thank for referring you to our office?

Signature of Parent or Guardian

Date

### Office Use Only

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	Jaw	RIGHT SIDE		LEFT SIDE	
		Molar	Cuspid	Molar	Cuspid
Class I					
Class II					
Div.I					
Div.II					
Class III					

Oral Hygiene ☐ Excellent ☐ Good ☐ Fair ☐ Poor

TMJ ☐ Normal ☐ Popping/Crepitus L/R ☐ Pain/L/R

Lip/Muscle Posture ☐ Lip Strain ☐ Mentalis Strain

Arch length:

Upper ☐ Excess ☐ Adequate ☐ Deficient \_\_\_\_\_mm

Lower ☐ Excess ☐ Adequate ☐ Deficient \_\_\_\_\_mm

Overbite ☐ Deep ☐ Normal ☐ Open \_\_\_\_\_%

Overjet \_\_\_\_\_mm

Habits ☐ Tongue thrust ☐ Thumb/finger

☐ Mouthbreathing

Abnormal frenum ☐ Upper ☐ Lower

Probable ☐ Extraction ☐ Non-Extraction ☐ Borderline

Crossbite: R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L  
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Midline R \_\_\_\_\_ L

Deciduous Teeth R E D C B A | A B C D E L  
E D C B A | A B C D E

Missing

Permanent Teeth R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L  
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommendation: ☐ Treat Now \_\_\_\_\_

☐ Recall: ☐ 3 mo. ☐ 6 mo. ☐ 1 yr.

☐ No treatment

Estimated Tx Time \_\_\_\_\_ Months \_\_\_\_\_ Fee

U/L Clarity \_\_\_\_\_

U/L Invisalign \_\_\_\_\_

Next Appt: \_\_\_\_\_

Letters:

☐ Records TBD ☐ Wait for TX ☐ NC ☐ TY Re ☐ FU Pt