

Berkinshaw Orthodontics, P.A.
New Patient Information Form (Child)

Patient's Information:

Patient's Name _____
Nickname _____
Birth Date _____ Age _____ Gender _____ School _____
Grade _____
Address _____ City _____ Zip _____
Home Phone _____ E-mail _____
Address _____
Dentist _____ Last Visit _____
Favorite Sports or Hobbies _____
Parent or Legal Guardian _____

Patient's Residence: Both Parents Mother Father Other

Siblings' Names and Ages (if applicable) _____
Whom May We Thank for Referring You to Our Office? _____

Parent's Information:

Father's Name (if applicable) _____

Birth Date _____ Marital Status _____
Address _____ City _____ Zip _____
Home Phone _____ Work Phone _____
E-mail Address _____ SS# _____
Employer _____ Job Title _____ # of Years _____

Mother's Name (if applicable) _____

Birth Date _____ Marital Status _____
Address _____ City _____ Zip _____
Home Phone _____ Work Phone _____
E-mail Address _____ SS# _____
Employer _____ Job Title _____ # of Years _____

Who is Responsible for making Appointments?

Name _____ Relationship _____
Home # _____ Work # _____

Person Financially Responsible for Account

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Home # _____ Work # _____ SS# _____

Employer _____ Title _____ # of Years _____

Orthodontic Insurance Information

Primary Insurance Company _____ Group # _____ Phone # _____

Insured's Name _____ Birth Date _____

Employer _____ SS# _____

Secondary Insurance Company _____ Group # _____ Phone # _____

Insured's Name _____ Birth Date _____

Employer _____ SS# _____

Health History

If the **Patient HAS** or **HAS HAD** any of the following, please indicate:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Frequently stuffed nose | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Drug Sensitivities | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Thumb or Finger Sucking | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Previous orthodontic treatment | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> "Mouth Breather" | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Pregnant (presently) |

1. Does the patient have any special problems not listed above? Yes ___ No ___
Explain _____

2. Does the patient experience any pain of clicking in the jaws upon opening and/or closing?
Yes ___ No ___ Explain _____

3. Has the patient been under the care of a physician during the past two years (other than routine checks)? Yes ___ No ___ Explain _____

4. Is the patient taking any medications? Yes ___ No ___
List _____

5. Is the patient actively growing? Yes ___ No ___ # of inches in last 6 months _____

6. Patient's physical development resembles: Father ___ Mother ___ Neither ___ Both ___
Father's Height _____ Mother's Height _____

7. Has the patient reached puberty? Yes ___ No ___ Not Sure ___

8. Female: Has menstruation begun? Yes ___ No ___ At what age?
Year ___ Month _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor)

Relationship _____ Date _____