



We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Today's date: _____

ABOUT YOUR TEEN

Name: _____ o Female o Male

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

School: _____ Grade: _____

Birth date: ____/____/____ Social security number: _____

Fathers Name: _____

Birth Date: ____/____/____ Social security number: _____

Work phone: _____ Cell phone: _____

Employer: _____

Insurance Co.: _____ Group: _____

ID #: _____ Ins. Phone: _____

Mothers Name: _____

Birth Date: ____/____/____ Social security number: _____

Work phone: _____ Cell phone: _____

Employer: _____

Insurance Co.: _____ Group: _____

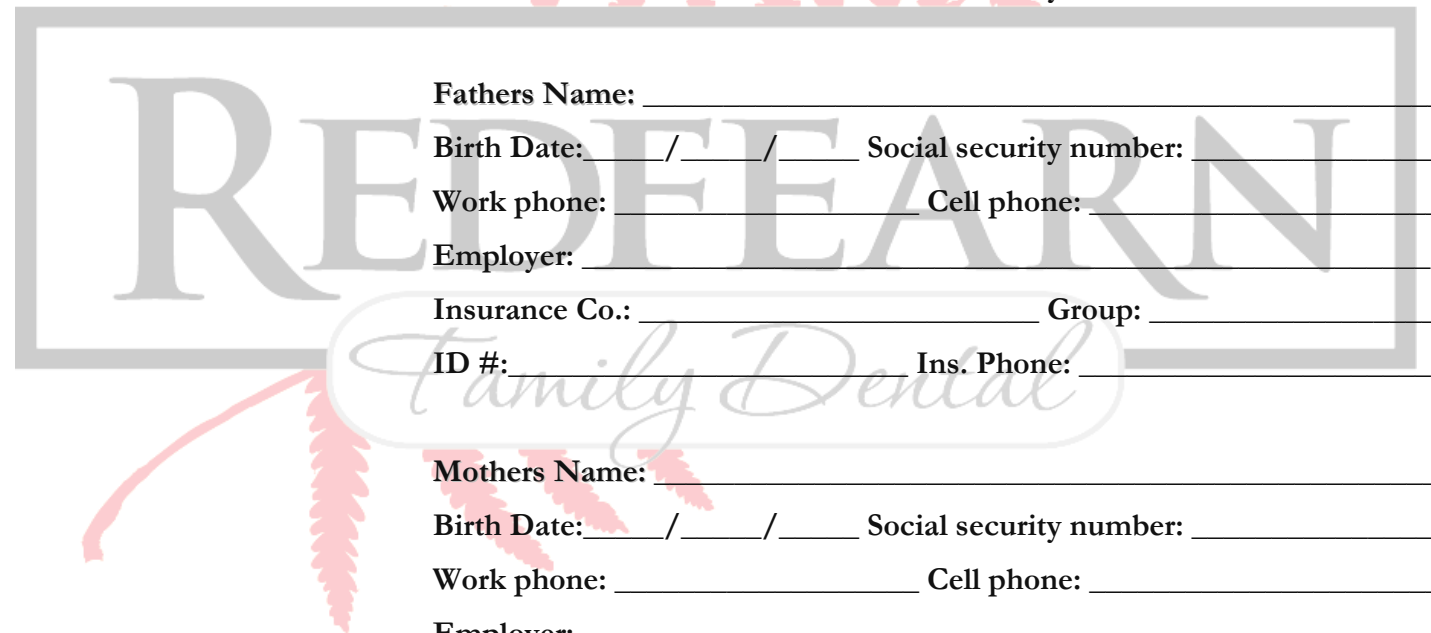
ID #: _____ Ins. Phone: _____

Who is responsible for child's account: _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone: _____



DENTAL HISTORY

How do you feel about your smile? _____

What was your approximate age at your first dental experience? _____

Has your dental care been regular? ☐ Yes ☐ No

Are you currently in braces? ☐ Yes ☐ No How much longer? _____

Have you ever had: ☐ orthodontic treatment? ☐ oral surgery? ☐ root canal treatment?

☐ clicking or popping of the jaw joint (TMJ)? ☐ sensitivity to heat, cold or pressure?

How do you brush your teeth? ☐ vigorously ☐ moderately ☐ lightly ☐ what's brushing

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do you smoke or chew tobacco? ☐ Yes ☐ No How often? _____

How many sodas do you drink a day? _____ What kind? _____

How many times a day do you snack? _____ What do you snack on? _____

MEDICAL HISTORY

When was your teens last medical exam? Date _____ Year _____

Has your teen required hospitalization or had a serious illness? ☐ Yes ☐ No

If yes, please explain: _____

Are your teens immunizations up-to-date? ☐ Yes ☐ No

Is your teen sensitive/allergic to anything? ☐ Yes ☐ No

If yes, please explain: _____

Is your teen presently taking any medications? ☐ Yes ☐ No

If yes, please explain: _____

Please check any of the following that apply to your teen:

- | | | | |
|------------------------------------------|-------------------------------------|-------------------------------------------|---------------------------------------------|
| <input type="radio"/> Rheumatic fever | <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Counseling |
| <input type="radio"/> Heart murmur | <input type="radio"/> Hay fever | <input type="radio"/> Breathing disorders | <input type="radio"/> Mitral valve prolapse |
| <input type="radio"/> Epilepsy | <input type="radio"/> Anemia | <input type="radio"/> Hearing impairment | <input type="radio"/> Visual impairment |
| <input type="radio"/> Attention disorder | <input type="radio"/> Latex Allergy | <input type="radio"/> Penicillin Allergy | <input type="radio"/> Sulfa Allergy |

Is there any additional information that you feel would be helpful in meeting your personal needs?:

Teen Signature _____ Date _____

Guardian Signature _____ Date _____