ID#_____

Springfield Orthodontics

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368 River Street, Suite 100, Springfield, VT 05156

(802) 886-2552

Welcome to our office! Thank you for answering these questions about your child.

Your Child

Child's Full Legal Name _____ Nickname_____
First Middle Last

Sex: M _____ F _____ Date of Birth _____ Age _____ Social Security #_____

Child's Home Address _____ Town _____ State ____ Zip Code _____

Mailing Address *(if different)* _____ Town _____ State ____ Zip Code _____

Child's Dentist _____ Date of Last Visit _____

Child's Physician _____ Date of Last Visit _____

School _____

How often is child absent from school? Never _____ Seldom _____ Frequently _____

Parent/Guardian Information

☐ ***Biological Mother*** ☐ ***Guardian***

Name _____

Date of Birth _____

Address *(if different)* _____

Town _____ State_____ Zip Code_____

Phone _____ Cell _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS # _____

Name of Mother's ☐ Spouse ☐ Significant Other

_____

☐ ***Biological Father*** ☐ ***Guardian***

Name _____

Date of Birth _____

Address *(if different)* _____

Town _____ State_____ Zip Code_____

Phone _____ Cell _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS # _____

Name of Father's ☐ Spouse ☐ Significant Other

_____

Whom may we thank for referring you to our office? _____

Do you have insurance which may cover orthodontics? _____

(If yes, please fill out green insurance information sheet)

Who will be primarily responsible for bringing child to appointments? _____

Relationship to child _____ ***Telephone #*** _____

Orthodontic Concerns

What is the orthodontic problem as you see it? _____

Indicate child's concern for correcting the problem:

Very concerned _____ Concerned _____ Indifferent _____ Opposed _____

Indicate your concern for correcting the problem:

Very concerned _____ Concerned _____ Indifferent _____ Opposed _____

Please describe child's coping style: Worrier _____ Easy going _____ Likes explanations _____

Has child had any previous orthodontic treatment? _____ If so, name of orthodontist: _____

Has anyone in the family had orthodontic treatment? _____ If so, who? _____

Name of orthodontist _____

OVER →

Medical and Dental History

	Yes	*No*
Is child being treated for any medical condition? _____	☐	☐
If yes, please explain _____		
Is child taking any medication? _____	☐	☐
If so, what? _____	☐	☐
Does child have any allergies? _____	☐	☐
Asthma _____ Latex _____ Nickel/Metal _____ Drug _____ Other _____		
Have child's tonsils or adenoids been removed? _____ Age when removed _____	☐	☐
Does child suffer from frequent nasal obstruction, earaches, or sore throat? _____	☐	☐
Does child suffer from frequent headaches and/or jaw pain? _____	☐	☐
Has child had any history of accident/trauma to face or teeth? _____	☐	☐
If so, please explain _____		
Has child ever had a bad experience at a dental office? _____	☐	☐
Does child have emotional problems? _____	☐	☐
Does child have any learning disability? _____	☐	☐
Has there been any significant increase in height in the past six months to a year? _____	☐	☐
If child is female, has menstruation begun? _____ Age when begun _____	☐	☐

Does child have a history of any of any of the following?

	Yes	*No*		*Yes*	*No*
Heart problems _____	☐	☐	Anemia _____	☐	☐
Rheumatic fever/rheumatic heart disease__	☐	☐	Cancer_____	☐	☐
Heart murmur _____	☐	☐	Respiratory disease _____	☐	☐
Diabetes_____	☐	☐	Liver disease _____	☐	☐
Epilepsy or seizures _____	☐	☐	Kidney disease _____	☐	☐
Sores on lips or in mouth_____	☐	☐	Stomach/intestinal problems _____	☐	☐
Hepatitis_____	☐	☐	Impaired hearing_____	☐	☐
Tuberculosis_____	☐	☐	Impaired vision _____	☐	☐
HIV Infection _____	☐	☐	Mental health problems_____	☐	☐
Aids _____	☐	☐	Attention Deficit Disorder (ADD) _____	☐	☐
Thyroid disease _____	☐	☐	Obsessive Compulsive Disorder (OCD) ___	☐	☐
Prolonged bleeding _____	☐	☐	Other _____	☐	☐

Oral Habits

	Yes	*No*
Thumb or finger sucking _____ Age when stopped _____	☐	☐
Lip or cheek biting _____	☐	☐
Mouth breathing _____	☐	☐
Tooth clenching or grinding _____	☐	☐
Speech difficulties _____	☐	☐

Additional Comments

_____

_____

_____

SIGNATURE: _____ **Relationship to child** _____

DATE: _____