



Welcome!

CHILD FORM

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you.

Name _____ Birth Date: _____

First Middle Last
Name you go by _____ Sex: M F Age: ____/____/____ Grade: ____/____/____

Home Address _____
Street City State Zip

Home Phone # _____ Cell phone# _____
*would you like a text message reminder for appointments? YES NO

Email Address: _____ *would you like an email reminder? YES NO

Who may we thank for referring you _____ patient/doctor- advertising, location, TY sent: _____

Interests: _____ School: _____

Siblings: _____ age _____ / _____ age _____ / _____ age _____

Please list family members treated in our office. _____

Father/Guardian _____
 Address (if different) _____
 Employer _____
 Employer's Address _____
 Soc.Sec.# _____ Birthdate _____
 Do you have Dental Insurance? Yes / No **Please present card.**

Does Dad have any congenitally missing teeth? No/ Yes _____
 Had past Ortho treatment? No/ Yes _____
 Impacted teeth? No/ Yes _____ Canine/eye teeth _____

Mother/Guardian _____
 Address (if different) _____
 Employer _____
 Employer's Address _____
 Soc.Sec.# _____ Birthdate _____
 Do you have Dental Insurance? Yes / No **Please present card.**

Does Mom have any congenitally missing teeth? No/ Yes _____
 Had past Ortho treatment? No/ Yes _____
 Impacted teeth? No/ Yes _____ Canine/eye teeth _____

I give permission, release and authorize:

- ... Cheryl K. Cermin, D.D.S. and qualified staff to take diagnostic records for the purpose of planning orthodontic treatment.
- ... the use of the orthodontic records for professional consultations, research, education or publication in professional journals.
- ... any information from the insurance company relating to the orthodontic treatment.
- ... payment to Cheryl K. Cermin, D.D.S. for the group insurance benefits otherwise payable to me.
- ... I authorize Cheryl K. Cermin, D.D.S. to share this patient's treatment information with collaborating dentists and surgeons when appropriate.
- ... I authorize Cheryl K. Cermin, D.D.S. to submit treatment information pertinent to this patient to the insurance company for billing purposes only.
- ... THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Signature of Parent or Guardian/Patient _____ Date _____

Update (Initials) _____ Date _____ Update (Initials) _____ Date _____ Update(Initials) _____ Date _____

Update(Initials) _____ Date _____ Update(Initials) _____ Date _____ Update(Initials) _____ Date _____

Signature of CHERYL K. CERMIN DDS _____ Date _____

Medical/Dental History

General Dentist _____ Phone # _____
 Address/City _____ Last Cleaning Appointment _____
 Cavities/decay present? _____ Do you have an appointment scheduled for fillings/restorative? _____

Update: _____ LV: _____ decay? _____ Update: _____ LV: _____ decay? _____
 Update: _____ LV: _____ decay? _____ Update: _____ LV: _____ decay? _____

***WHAT IS YOUR MAIN ORTHODONTIC CONCERN?** _____
***IS THIS A SECOND ORTHODONTIC OPINION?** _____ Was there a Panoramic X-Ray taken? _____

Physician _____ City/State _____
 Last Well Check Appointment _____ Concerns: _____
Past or present : Specialist/Therapist _____
 Address/Clinic seen _____ City/ State _____
 Date of last appointment _____ Past Treatment : _____
 Future Appointments Needed? No/ Yes If yes, reason _____

Yes/ No Has the patient **recently** been evaluated for orthodontics? Doctor: _____ recommended _____
 Yes / No Has the patient had orthodontic treatment? Orthodontist: _____ City/State _____
 Age : _____ Treatment _____ retainers? _____
 Yes / No Has the patient had any injury to the mouth, face, teeth or chin? Date/Year _____ Age/grade _____
 Please describe _____
 Yes / No Has the patient had any noise/pain/stiffness/difficulty opening in the jaw joint? (TMJ/TMD) first noticed _____
 Right _____ Left _____ Level of pain: 0 to 10 _____ take pain medication? _____ Due to Accident? _____
 Yes / No Does the patient snore at night?..... **Yes / No** Difficult breathing thru mouth?..... **Yes/ No** Evaluated by an Ear Nose Throat?
 Yes / No Have tonsils been removed? Year _____ Age _____..... **Yes / No** Have adenoids been removed? Year _____ Age _____
 Yes / No Currently DOES the patient have a thumb habit?..... **Yes / No** Did the patient ever have a thumb habit? Age stopped: _____
 Yes / No Currently DOES the patient have a finger nail biting habit? _____
 Yes / No Is the patient in any contact sports? Football/ Basketball/ Hockey/ Wrestling/ Gymnastics/ Soccer/ Baseball/ Softball/ Skiing/
 Snowboarding/Boxing _____ **We would like to provide a mouth guard.**

PLEASE CIRCLE YES OR NO IF THE PATIENT HAS OR HAD ANY OF THE FOLLOWING:

YES _____ NO _____ Asthma-Medicine dependent? Y/N , allergy/exercise induced	YES _____ NO _____ AIDS/HIV
YES _____ NO _____ Abnormal bleeding/ Hemophilia/bleeding disorder	YES _____ NO _____ Ever take any diet medication(Fen-Phen)
YES _____ NO _____ MRSA: date _____	YES _____ NO _____ Hospitalized for any reason? Date: _____
YES _____ NO _____ Hepatitis/ jaundice/ liver disease	procedure: _____
YES _____ NO _____ Allergic reactions to _____	YES _____ NO _____ Blood Transfusion
hives/ rash/ breathing... _____ carry epi pen? _____	YES _____ NO _____ Severe frequent headaches / Migraines
YES _____ NO _____ Arthritis	YES _____ NO _____ Cleft lip/ Palate _____
YES _____ NO _____ Cancer: Type _____ chemo/ radiation Date: _____	YES _____ NO _____ Joint or Bone Implants _____
YES _____ NO _____ Congenital heart defect	YES _____ NO _____ Rheumatic fever/ Scarlet fever
YES _____ NO _____ Convulsions /epilepsy/ seizures	YES _____ NO _____ Kidney/ Liver problems
YES _____ NO _____ Diabetes	YES _____ NO _____ Sinus problems
YES _____ NO _____ Disability/Handicap: List _____	YES _____ NO _____ Speech problems/ speech therapy: age _____
YES _____ NO _____ Glaucoma	YES _____ NO _____ Tuberculosis _____ to _____
YES _____ NO _____ Hearing impairment _____	YES _____ NO _____ Venereal disease
YES _____ NO _____ Heart murmur, Innocent? Pre medicate needed? _____	YES _____ NO _____ Need ANTIBIOTICS for dental work
YES _____ NO _____ Autism _____	YES _____ NO _____ A.D.D./ A.D.H.D. diagnosed: _____
YES _____ NO _____ Currently taking any medications? Please list _____	

Additional medical information _____

Initial _____ Date _____ changes: _____ Initial _____ Date _____ changes: _____ Initial _____ Date _____

Initial _____ Date _____ changes: _____ Initial _____ Date _____ changes: _____ Initial _____ Date _____