



1616 Clear Lake City Blvd., Suite 108 • Houston, TX 77062 • 281-486-1018 • Fax: 281-486-1075

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?

- | | |
|---|---|
| <u>Yes/No</u> | <u>Yes/No</u> |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Kidney/Liver Problems |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Handicaps/Disabilities |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | |

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

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