Fey & Grey
ORTHODONTICS

18807 Beardslee Blvd * Suite #101 * Bothell, WA 98011 (425) 485-9633

Welcome to our office. So that we may become better acquainted, please complete <u>both</u> sides of this form.

CHILD PATIENT INFORMATION

Name: _____ Preferred name: _____

Home address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Sex: _____ Age: _____ School: _____ Grade: _____

Patient resides with: ☐Mother ☐Father ☐Both ☐Other _____

Home Phone: _____ Patient Interests: _____

Please describe your child's orthodontic problems: _____

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

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed

	FATHER	MOTHER
Name:		
Address (if different than above):		
City, State, Zip:		
Phone (if different than above):		
Occupation:		
Employer:		
Business Phone:		

Home E-Mail Address (Patient and Parent): _____

Person responsible for account if other than parent:

Name: _____ Address: _____ Phone: _____

Do you have insurance? Please complete the Insurance Information Sheet to help us assist you in determining benefits.

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential. Please inform us if any changes should occur.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Has your child experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your child's health recently? ☐ No ☐ Yes Explain: _____
Is your child currently under a physician's care? ☐ No ☐ Yes Explain: _____
Is your child currently taking any medications? ☐ No ☐ Yes List: _____
Is your child allergic to any medications? ☐ No ☐ Yes List: _____
Has your child received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your child's tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Has your child been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if your child has had any of the following conditions:

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Sleep Disorder	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (fever blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsilitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____
Comments:

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty? ☐ No ☐ Yes
Girls-- Has she started menstruation? ☐ No ☐ Yes When? _____
Boys-- Has his voice changed? ☐ No ☐ Yes When? _____
Height: _____ Do you feel growth is completed? ☐ No ☐ Yes
Father's Height: _____ Mother's Height: _____ Adopted? ☐ No ☐ Yes
Names and birthdates of patient's brothers and sisters: _____
Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes With whom:

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____
Frequency of dental checks: Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never ☐ Date of last visit: _____
Is there any unfinished care to be completed with child's dentist? ☐ No ☐ Yes Explain: _____
Is your child frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Has your child had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Has your child had any face dental injuries? ☐ No ☐ Yes Explain: _____
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Stopped: _____
Does your child play a musical instrument? ☐ No ☐ Yes What instrument? _____
Has your child consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes
Has your child had any previous orthodontic treatment? ☐ No ☐ Yes With whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____

Please check if there is any history of:

☐ Clenching teeth ☐ Muscular soreness around head/neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (if so, which sounds _____) ☐ Mouthbreathing: Awake _____ Asleep _____

I understand that this information is correct to the best of my knowledge. I will keep Fey & Grey Orthodontics informed of any changes in my contact information or health issues that may effect my childs care.

Parent's Signature: _____ Printed Name: _____
Date: _____ Reviewed By: _____