plaza orthodontics

JAMES W. KOHL AND ASSOCIATES

WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime. Please fill out both sides of this form.

ABOUT YOUR CHILD

Name:____________________________________Nickname:______________________

Age:_____Birth date:_____/_____/____Sex:______Home Phone:____________________

Home Address:____

STREET CITY ZIP

School:_____________________________________Grade:________________________

Hobbies / Sports / Instruments played:____

Referred by:____

General Dentist:__________________Last Visit Date:_____________________________

Other family members seen by us:____

Person responsible for account: ____

Relationship to Child:____

Address:____

(IF DIFFERENT FROM ABOVE) STREET CITY ZIP

Home Phone:____________________Business Phone:___________________________

Cell Phone:_____________________ Email Address: __________________________

FAMILY INFORMATION

Father's name:________________________Occupation:__________________________

Mother's name:_______________________Occupation:__________________________

Marital Status:___________________Child Living With:_________________________

Father's Height:_____________Mother's Height:____________Child's Height:_______________

PLEASE COMPLETE THE OTHER SIDE

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MEDICAL HISTORY

Has your child ever had the following?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Arthritis
Y N Artificial Valves / Joints
Y N Sinus Problems
Y N Allergies (Seasonal)
Y N Allergies to Medications
Y N Metal Allergies (Nickel)
Y N Latex Allergies
Y N High / Low Blood Pressure
Y N Severe / Frequent Headaches
Y N Emotional Problems
Y N Epilepsy / Seizures
Y N Diabetes / Tuberculosis
Y N Blood Disorders
Y N Endocrine Problems
Y N Hepatitis
Y N Hearing Disorders

Has your child reached puberty?
☐YES ☐NO

Physician:___________________________

Present Medications:__________________

____

DENTAL HISTORY

Has your child ever had the following?

Y N Previous Orthodontic Evaluation
Date:__________________________
Y N Previous Orthodontic Treatment
Date:__________________________
Y N Pain / Discomfort in Jaw Joint
(TMJ / TMD)
Y N Injury to the Face or Jaw
Y N Injury to the Teeth
Y N Grinding of the Teeth
Y N Clenching of the Teeth
Y N Tongue Thrusting
Y N Mouth Breathing
Y N Nail Biting / Chewing Habits
Y N Thumb / Finger Sucking
Y N Sleep Apnea
Y N Snoring
Y N Difficulty with Extractions /
Other Dental Treatment
Y N Numerous Cavities
Y N Speech Problems

Reason for today's visit:____________

____

____

Additional Comments/
Explanations:_________________________

____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical or dental status.

____

SIGNATURE DATE

Thank you for filling out this form completely.

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