

# Child Consult Request

\*Required Fields must be filled out accordingly, in order to successfully submit the form.

## ABOUT YOUR CHILD

\*Child's First Name:

\*Child's Last Name:

They prefer to be called:

\*Child's Date of Birth:

Child's Email:

## RESPONSIBLE PARTY / CONTACT PERSON

\*First Name:

\*Last Name:

\*Relationship to patient:

mother     father     other

Other relative, please explain:

\*Mailing Address:

\*Home Phone:

Cell Phone:

Home Email:

Do you have orthodontic insurance?

yes     no     not sure

Name of Employer:

Business Phone:

Business Email:

### \*PREFERRED FORM OF CONTACT:

Home Phone     Home Email     Business Phone     Business Email     Cell Phone

## FINANCIALLY RESPONSIBLE PARTY (if different from above)

\*First Name:

\*Last Name:

\*Relationship to patient:

mother     father     other

Other relative, please explain:

\*Mailing Address:

\*Home Phone:

Cell Phone:

Home Email:

Do they have orthodontic insurance?

yes       no       not sure

Name of Employer:

Business Phone:

Business Email:

**ALTERNATE CONTACT PERSON/PARENT**

First Name:

Last Name:

Relationship to patient:

mother       father       other

Other relative, please explain:

**If different from above:**

Mailing Address:

Home Phone:

Cell Phone:

Home Email:

Name of Employer:

Business Phone:

Business Email:

**GENERAL INFORMATION**

How did you hear about our office?

Who may we thank for referring you?

Child's Dentist:

Child's Family Physician:

**MEDICAL HISTORY**

Does your child have allergies?

yes       no

If yes, please indicate what the allergy is:

Does your child have a heart condition requiring antibiotics before dental procedures?

yes       no       not sure

If yes, please explain:

Has your child been hospitalized in the last year?

yes  no

If yes, please explain:

Is your child currently taking medication?

yes  no

If yes, please explain:

Does your child have any muscle or arthritis problems?

yes  no

If yes, please explain:

Does your child suffer from snoring or sleep apnea?

yes  no

If yes, please explain:

Does your child have any tonsil or adenoid problems?

yes  no

If yes, please explain:

**Please explain any other medical problems:**

### **DENTAL / ORTHODONTIC HISTORY**

Are you aware of any of the following problems:

Thumb or finger habit

yes  no

Mouth breathing

yes  no

Speech problems

yes  no

Tongue thrust

yes  no

Has your child been evaluated for orthodontic treatment in the past?

yes  no

If yes, by whom and when?

Has your child had orthodontic treatment in the past?

yes  no

If yes, by whom and when?

Has your child had periodontal (gum) treatment?

yes  no

If yes, by whom and when?

Has your child ever had any injuries to his/her teeth?

yes  no

If yes, please explain:

Are you happy with your child's smile?

yes  no

If not, what would you change?

Are you happy with the profile of your child's face/bite?

yes  no

If not, what would you change?

### **JAW PAIN / TMJ HISTORY**

Is your child currently wearing a biteplane or night guard?

yes  no

Has your child ever worn a biteplane or night guard in the past?

yes  no

Is your child or has your child experienced jaw pain?  yes  no  
If yes, please explain:

Has your child been treated for jaw pain or TMJ?  yes  no  
If yes, please explain:

Has your child ever received a blow/trauma to their jaw?  yes  no  
If yes, please explain the incident:

Has your child experienced any of the following issues:

Grinding their teeth	<input type="checkbox"/> yes	<input type="checkbox"/> no
Clench their teeth	<input type="checkbox"/> yes	<input type="checkbox"/> no
Noise in the joint when opening/closing	<input type="checkbox"/> yes	<input type="checkbox"/> no
Jaw locking open/closed	<input type="checkbox"/> yes	<input type="checkbox"/> no
Ringling/fullness in the ears	<input type="checkbox"/> yes	<input type="checkbox"/> no
Headaches	<input type="checkbox"/> yes	<input type="checkbox"/> no

**PERSONAL**

What extra-curricular activities or hobbies does your child enjoy?

Does you child participate in sports?   
If so, which ones?

Is there anything else you would like to add?

**Do you have any friends or family that are undergoing treatment or have had treatment at our office?**  yes  no

Family member's name(s):

Friend's name(s):

**How was their overall experience?**  
 excellent  good  fair  not sure

**Do you have any friends or family who may also be interested in a consultation?**  yes  no

First Name:

Last Name:

Home Phone:

Email:

**\*\*\* If you refer a friend or family member for a consultation, your name is entered into our monthly referral draw to win a prize. If that friend or family member starts his/her treatment with us, you will receive a \$100.00 referral gift!**