***JOHN J. MARCHETTO, D.M.D.***
***MARISSA N. COOPER, D.M.D, MS***

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 lasts a lifetime.

## 1 Tell us about your child

**Today's Date:**_____

**Child's Name:**_____

Nickname:_____

Child's Birthdate:____/____/____ Child's Age:_____Sex:_____

School:_____

Hobbies / Sports:_____

Child's Home #:_____

**Child's Home Address:**_____
Apt/Condo #

_____
City State Zip

## 2 Who is accompanying your child today?

Name:_____ Relation:_____

Do you have legal custody of this child? Yes No

Custodial parent's names_____

Parent's Marital Status: Married Divorced Separated Single Widowed

List brothers/sisters & age; (Please include if they have had any orthodontic treatment.)

_____

## 3 Mother's Information: Step Mother Guardian

Name:_____

Title: Mrs. Ms. Miss Dr. Other _____

HM#:_____WK#:_____Cell#:_____

Employer:_____

Occupation:_____

Email:_____

## 4 Father's Information: Step Father Guardian

Name:_____

Title: Mr. Dr . Other_____

HM #:_____ WK#:_____Cell#:_____

Employer:_____

Occupation:_____

Email:_____

## 5 Person Responsible for Account

Name:_____

Billing Address:_____

_____
City State ZIP

HM#:_____ WK#:_____ Cell#_____

Employer:_____

Occupation:_____

***Who is responsible for making appointments?***

Name:_____

HM#:_____ WK#:_____ Cell#_____

Email:_____

## 6 Primary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group # (Plan, Local, or Policy #):_____

*Insured's* Name:_____

Relationship to Patient:_____

*Insured's* Birthday: ___/___/___ & ID#:_____

*Insured's* Employer:_____

## 7 General Information

*General Dentist:*_____

Last Visit Date:_____

What concerns you about your child's teeth?_____

What concerns your child about his/her teeth?:_____

How does your child feel about orthodontic treatment?
_____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office?_____

Describe any previous orthodontic treatment or consultations.
_____

Whom may we Thank for referring you?_____

## 8 Dental Information

Have there been any injuries to the face, mouth, teeth or chin?
Yes No
List any musical instruments played_____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing permanent teeth?
Yes No
Has your child been informed of any extra teeth?
Yes No
Has your child chipped or injured primary or permanent teeth?
Yes No
Has your child ever had any pain / tenderness/ clicking/ locking in the jaw joint (TMJ / TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Child's Physician:_____
Phone #:_____Date of Last Visit:_____
Is your child currently under the care of a physician?
Yes No
Has your daughter's menstruation begun? Yes No
Please describe your child's current physical health:
Good Fair Poor
Please list all drugs that your child is currently taking:
_____

Taken for?_____

Please list all drugs that your child is allergic to:
_____

Has your child ever been told that he/she must take antibiotics prior to dental appointments? Yes or No

## 9 Has your child ever had any of the following medical problems?

| | | | |
|---|---|---|---|
| **Y N** | **Allergy to Plastic** | **Y N** | **Allergy to Latex / Metals** |
| **Y N** | **Heart Murmur** | **Y N** | **Congenital Heart Disease** |
| **Y N** | **Cancer** | **Y N** | **Convulsions / Epilepsy** |
| **Y N** | **Diabetes** | **Y N** | **Abnormal Bleeding** |
| **Y N** | **Rheumatic Fever** | **Y N** | **Hearing Impairment** |
| **Y N** | **HIV+ / AIDS** | **Y N** | **Any Operations** |
| **Y N** | **Hemophilia** | **Y N** | **Any stays in a Hospital** |
| **Y N** | **Asthma** | **Y N** | **Kidney / Liver Problems** |
| **Y N** | **Hepatitis** | **Y N** | **Handicaps / Disabilities** |
| **Y N** | **Tuberculosis (TB)** | **Y N** | **Allergies to any Drugs** |
| Y N | **Birth defects** | **Y N** | **Arthritis/joint problems** |
| **Y N** | **Frequent Headaches** | **Y N** | **Endocrine/Thyroid Problems** |
| **Y N** | **Allergy to Anesthetics** | **Y N** | **Eating disorders** |

**Please discuss any medical problems that your child has had:**
_____
_____
_____

## 10 Does your child have any of the following habits?

| | | | |
|---|---|---|---|
| **Y N** | **Thumb / Finger Sucking** | **Y N** | **Mouth Breathing** |
| **Y N** | **Lip Sucking / Biting** | **Y N** | **Speech Problems** |
| **Y N** | **Clenching / Grinding Teeth** | **Y N** | **Nail Biting** |
| **Y N** | **Nursing Bottle Habits** | **Y N** | **Tongue Thrusting** |

**10** I understand that the information which I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____
Signature of parent or guardian Date