Kulits Orthodontics Date_____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Confidential Parent/Guardian Information

Name _____ □ Married □ Single □ Separated
Last First Middle

Residence_____ □ Own □ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____Work Phone _____Cell Phone _____

Social Security #_____ Birthdate _____ Relationship to Patient_____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____ Relationship to Patient _____ Birthdate _____
Last First Middle

Employer _____ Occupation_____ # Years Employed _____

Insurance Information

Policy Holder's Name _____ Soc. Sec. # /or ID #_____

Insurance Company _____ Group # _____Union Local # _____

Insurance Co. Address _____Insurance Co. Phone_____

Policy Holder's Employer _____

Do you have dual coverage? No □ Yes □ If yes: _____

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor) _____

Updates (date and initial) _____

Please complete the Medical History on the reverse side

Medical History

What are your main reasons/concerns for seeking orthodontic treatment? _____

_____

Has your child ever been evaluated or had orthodontic treatment before? □ Yes □ No

If so, what type of treatment has been discussed? _____

Have there been any injuries to your child's face, mouth, teeth, or chin? □ Yes □ No

Names and ages of other children living at home: _____

Did Mother or Father ever wear braces? □ Yes □ No

List any musical instruments played: _____

Hobbies: _____

Have your child's adenoids and/or tonsils been removed?	□ Yes	□ No
Does your child snore or have sleep apnea?	□ Yes	□ No
Have you been informed of any missing or extra permanent teeth?	□ Yes	□ No
Has your child ever had any pain/tenderness in the jaw joint (TMJ/TMD)?	□ Yes	□ No
Does your child brush his/her teeth daily?	□ Yes	□ No
Does your child floss his/her teeth daily?	□ Yes	□ No

Child's dentist: _____ Date of last visit: _____

Child's physician: _____

Phone #_____ Date of last visit: _____

Is your child currently under the care of a physician?		□Yes	□ No
Has puberty begun?		□ Yes	□ No
Has menstruation begun (girls)?		□ Yes	□ No
Please describe your child's current physical health:	□ Good	□ Fair	□ Poor

Please list all the medications that your child is currently taking: _____

Please list all the medications that your child is allergic to: _____

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

Abnormal Bleeding	□ Yes □ No	Diabetes	□ Yes □ No	Allergy to Plastic	□ Yes □ No
Allergy to Latex/Metals	□ Yes □ No	Hearing Impairment	□ Yes □ No	Heart Murmur	□ Yes □ No
Handicaps/Disabilities	□ Yes □ No	Hemophilia	□ Yes □ No	Hepatitis	□ Yes □ No
Any Hospital Stays	□ Yes □ No	Any Operations	□ Yes □ No	Asthma	□ Yes □ No
Kidney/Liver Problems	□ Yes □ No	Cancer	□ Yes □ No	HIV / AIDS	□ Yes □ No
Convulsions/Epilepsy	□ Yes □ No	Rheumatic Fever	□ Yes □ No	Tuberculosis (TB)	□ Yes □ No
Congenital Heart Defect	□ Yes □ No	Snoring/Sleep Apnea	□ Yes □ No		

Please describe any medical problems your child has or has had: _____

_____

Does your child have any of the following habits?			
Speech Problems	□ Yes □ No	Clenching/ Grinding	□ Yes □ No
Mouth Breather	□ Yes □ No	Lip Sucking/Biting	□ Yes □ No
Nail Biting	□ Yes □ No	Thumb/Finger Sucking	□ Yes □ No
		Tongue Thrust	□ Yes □ No

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

_____ _____

Signature of Parent or guardian Date