



DOWNEY ORTHODONTICS

Dr. Nathan M. Downey

Creating Smiles for a Lifetime.



Member
American
Association of
Orthodontists

Please complete this form with as much detail as possible. This confidential information will become a part of our patient records.

Child or Teen Information

Date _____ Male Female

Child's Full Legal Name _____ Preferred Name _____

Date of Birth _____ Age _____ School _____ Grade _____

Personal Interests or Hobbies _____

Name and Ages of Siblings _____

Address _____
 Street City State Zip

E-mail Address _____ Home Phone _____

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

Contact Information

<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____	<input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Name _____	Name _____
Address (If different than child's) _____ Street City State Zip	Address (If different than child's) _____ Street City State Zip
Home Phone _____ Cell Phone _____	Home Phone _____ Cell Phone _____
Birth Date _____	Birth Date _____
Social Security Number _____	Social Security Number _____
Employer _____	Employer _____
Occupation _____	Occupation _____
Work Phone _____	Work Phone _____

If divorced or separated, who is the Custodial Parent? Mother Father Joint

Insurance Information

Primary Insurance: Subscriber's Name _____ Relationship to Patient _____
 Employer _____ Insurance Name _____

Secondary Insurance: Subscriber's Name _____ Relationship to Patient _____
 Employer _____ Insurance Name _____

Please allow us to make copies of your insurance cards.

Emergency Information

Name of nearest relative not living with you _____ Relationship _____
 Address _____ Phone _____

Dental History

Child's Dentist _____ Date of last exam _____

Has child been to an orthodontist before? Yes No Have other family members had orthodontic treatment? Yes No

What are the main concerns you have about your child's teeth? _____

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Does/did your child suck their thumb/finger?	<input type="checkbox"/> <input type="checkbox"/> Has your child been informed of any missing/extra teeth?
<input type="checkbox"/> <input type="checkbox"/> Does your child suck/bite their lip?	<input type="checkbox"/> <input type="checkbox"/> Does child clench/grind teeth?
<input type="checkbox"/> <input type="checkbox"/> Does your child breathe through their mouth?	<input type="checkbox"/> <input type="checkbox"/> Does child have headaches?
<input type="checkbox"/> <input type="checkbox"/> Does your child have speech problems?	<input type="checkbox"/> <input type="checkbox"/> Does child have pain when opening or closing their mouth?
<input type="checkbox"/> <input type="checkbox"/> Has your child had any injuries to the face, mouth, or teeth?	<input type="checkbox"/> <input type="checkbox"/> Has child had a negative reaction to dental or medical care?
<input type="checkbox"/> <input type="checkbox"/> Does your child have any "gum" problems (periodontal disease)?	

Medical History

Medical Doctor _____ Date of last exam _____

Under care of doctor now? Yes No Phone Number _____

Medications being taken now _____

Has your child experienced:

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Blood Disorders	<input type="checkbox"/> <input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> <input type="checkbox"/> Drug Allergies	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Allergies to latex/metals	<input type="checkbox"/> <input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> <input type="checkbox"/> Allergies to plastic	<input type="checkbox"/> <input type="checkbox"/> Kidney/Liver Problems
<input type="checkbox"/> <input type="checkbox"/> Any operations	<input type="checkbox"/> <input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> <input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> ADHD

Are there any medical conditions not listed above that you feel we need to be aware of? _____

Is antibiotic premedication required before dental procedures? Yes No

Allergies _____

Please discuss any medical problems that your child has that might have an effect on his/her treatment in our office:

For growth purposes, has your child gone through puberty? Yes No Just Beginning

Has menstration begun (girls)? Yes No Are you pregnant (girls)? Yes No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Downey Orthodontics to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature

Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient.

Initials _____ Date _____

Comments _____

MEDICAL HISTORY UPDATE

I have reviewed my child's dental and medical history and confirm that it is current and complete.

Signature

Date

Signature

Date

REV 5/24/11

Thank you for the trust and confidence you've placed in me to take care of your orthodontic needs. - Nathan M. Downey, DDS, MS