



**DYER & ROBINSON**  
Orthodontics

**CHILD ORTHODONTIC PATIENT INFORMATION**

Date \_\_\_\_\_ Nickname \_\_\_\_\_

Patient's Name \_\_\_\_\_ Adopted? \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_  
Month Day Year

Address \_\_\_\_\_  
Street City State Zip

E-mail Address \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

General Dentist \_\_\_\_\_ Family Physician \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Main reason(s) for seeking orthodontic treatment \_\_\_\_\_

Patient's hobby or special interest \_\_\_\_\_

Father's Name \_\_\_\_\_

Employed by \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

Employed by \_\_\_\_\_ Phone \_\_\_\_\_

**NAME OF RESPONSIBLE PARTY FOR ACCOUNT** \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

No. of years at this address? \_\_\_\_\_ Previous address (if less than 3 yrs.) \_\_\_\_\_

Work phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ No. of Yrs \_\_\_\_\_

Is the patient covered by orthodontic insurance? \_\_\_\_\_ Primary insured's DOB \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Insurance Co. telephone \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Insurance Co. telephone \_\_\_\_\_

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## Medical History

- Is the patient in good health? **Yes No** Explain: \_\_\_\_\_
- Does the patient have any major or unusual illnesses? **Yes No** Explain: \_\_\_\_\_
- Is the patient currently under the care of a physician? **Yes No** Reason: \_\_\_\_\_
- Does the patient have any allergies? **Yes No** List: \_\_\_\_\_
- Does the patient have any drug sensitivities? **Yes No** List: \_\_\_\_\_

Please indicate if the child has or has ever had any of the following:

- | Yes | No  | Yes | No  | Yes | No  |
|-----|-----|-----|-----|-----|-----|
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
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| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |

## Dental History

- Yes No**
- \_\_\_ \_\_\_ Does the patient see a dentist regularly?
- \_\_\_ \_\_\_ Has the patient had any severe head or facial injuries? Explain: \_\_\_\_\_
- \_\_\_ \_\_\_ History of thumb or finger sucking? Has the habit ceased? \_\_\_\_\_ At what age? \_\_\_\_\_
- \_\_\_ \_\_\_ Has the patient consulted with an orthodontist previously?
- \_\_\_ \_\_\_ Has the patient had any previous orthodontic treatment? Explain: \_\_\_\_\_
- \_\_\_ \_\_\_ Did either parent have orthodontic treatment? Did the treatment involve jaw surgery? \_\_\_\_\_
- Does the patient have any siblings? \_\_\_\_\_ Names and ages: \_\_\_\_\_
- \_\_\_\_\_ Have any of them had orthodontic treatment? \_\_\_\_\_

Please check if there is a history of:

- \_\_\_ Jaw joint popping \_\_\_ Jaw joint clicking \_\_\_ Jaw joint pain/soreness \_\_\_ Frequent headaches
- \_\_\_ Grinding teeth \_\_\_ Clenching teeth \_\_\_ Ringing in the ears \_\_\_ Head or neck muscle soreness

Is there any other info about your child that may be important for us to know? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

