



**ORTHODONTIC SPECIALISTS**  
**Drs. Welch & Bonds, P.A.**

PLEASE PRINT IN INK

**PATIENT INFORMATION**

**CHILD NEW PATIENT FORM**

LAST NAME	FIRST NAME	M.I.	BIRTHDATE	AGE	SEX	SCHOOL
MAILING ADDRESS		CITY	STATE	ZIP	HOME PHONE	
PATIENT'S DENTIST	LAST DENTAL VISIT	PATIENT'S HOBBIES OR INTERESTS				
IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.)						

**PARENT INFORMATION**

FATHER'S NAME	FATHER'S SS#	FATHER'S ADDRESS (IF DIFFERENT)				
OCCUPATION	EMPLOYER	FATHER'S WORK PHONE	FATHER'S CELL PHONE	FATHER'S EMAIL		
MOTHER'S NAME	MOTHER'S SS#	MOTHER'S ADDRESS (IF DIFFERENT)				
OCCUPATION	EMPLOYER	MOTHER'S WORK PHONE	MOTHER'S CELL PHONE	MOTHER'S EMAIL		
PARENTS MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOW(ER)						

**RESPONSIBLE PARTY INFORMATION**

NAME OF PERSON RESPONSIBLE FOR ACCOUNT	RELATIONSHIP TO PATIENT	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOW(ER)
IMMEDIATE FAMILY MEMBERS THAT ARE OR HAVE BEEN PATIENTS OF OURS		
WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?	EMERGENCY CONTACT PHONE	ALTERNATE CONTACT NAME AND PHONE (IF ANY)
DO YOU HAVE DENTAL INSURANCE THAT COVERS ORTHODONTIC TREATMENT?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
LIST PERSONS WHO MAY RECEIVE INFORMATION REGARDING PATIENT'S TREATMENT IN YOUR ABSENCE:(WHO MIGHT ACCOMPANY PATIENT TO APPOINTMENT)		

**MEDICAL HISTORY**

PHYSICIAN	LIST ANY ALLERGIES
LIST ALL DRUGS, VITAMINS, SUPPLEMENTS, OR MEDICATIONS	FEMALES: HAS MENSTRUATION BEGUN? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, WHAT MONTH/YEAR?

PLEASE CHECK IF YOU HAVE HAD THE FOLLOWING

YES <input type="checkbox"/> NO <input type="checkbox"/> JOINT SWELLING	YES <input type="checkbox"/> NO <input type="checkbox"/> SLEEP APNEA/SNORING	YES <input type="checkbox"/> NO <input type="checkbox"/> HIGH BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/> DIABETES
YES <input type="checkbox"/> NO <input type="checkbox"/> BONE DISORDERS	YES <input type="checkbox"/> NO <input type="checkbox"/> SLEEPING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/> ANEMIA
YES <input type="checkbox"/> NO <input type="checkbox"/> HEART TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/> EMOTIONAL PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> FAINTING / DIZZINESS	YES <input type="checkbox"/> NO <input type="checkbox"/> TONSILITIS
YES <input type="checkbox"/> NO <input type="checkbox"/> MITRAL VALVE PROLAPSE	YES <input type="checkbox"/> NO <input type="checkbox"/> TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/> ASTHMA/ ALLERGIES	YES <input type="checkbox"/> NO <input type="checkbox"/> EARACHES
YES <input type="checkbox"/> NO <input type="checkbox"/> RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/> KIDNEY OR LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/> ARTHRITIS
YES <input type="checkbox"/> NO <input type="checkbox"/> THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> ARTIFICIAL JOINTS	YES <input type="checkbox"/> NO <input type="checkbox"/> HIV OR AIDS
LIST ANY OTHER SERIOUS ILLNESSES OR PROBLEMS			

**DENTAL HISTORY**

YES <input type="checkbox"/> NO <input type="checkbox"/> ANY INJURY TO FACE, MOUTH, OR TEETH?	YES <input type="checkbox"/> NO <input type="checkbox"/> ANY DIFFICULTY IN SWALLOWING OR CHEWING?
YES <input type="checkbox"/> NO <input type="checkbox"/> ANY PAIN IN OPENING OR CLOSING MOUTH?	YES <input type="checkbox"/> NO <input type="checkbox"/> HAVE YOU CONSULTED AN ORTHODONTIST PREVIOUSLY?
YES <input type="checkbox"/> NO <input type="checkbox"/> THUMB OR FINGER HABITS? UNTIL WHAT AGE? _____	YES <input type="checkbox"/> NO <input type="checkbox"/> DOES PATIENT HAVE ANY MISSING OR EXTRA PERMANENT TEETH?

ADDITIONAL INFORMATION WHICH YOU FEEL WE SHOULD KNOW ABOUT TO BEST SERVE YOU:

To the best of my knowledge, the above information is complete and correct. I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. I understand and consent that the information provided may be used to obtain credit reports as necessary.

Date \_\_\_\_\_

Signature \_\_\_\_\_