WELCOME TO

DR. CHARLES P. CANEPA

orthodontist

Tell us about your child:

Today's date: _____

Child's name: _____
LAST FIRST MI

Nickname: _____

☐ Male ☐ Female

Child's birthdate: _____

Age: _____

School: _____

Grade: _____

Hobbies/Sports: _____

Child's home phone#: _____

Child's home address: _____
APT/CONDO#

_____
CITY STATE ZIP

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

Has there been any injury 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 or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in his or her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Floss 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 puberty begun? ☐ Yes ☐ No

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

_____

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

_____

Who is accompanying your child today?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we THANK for referring you? _____

List brothers/sisters with age: _____

_____

General dentist: _____

Last visit: _____

Parent's marital status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

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

Y N	Abnormal Bleeding	Y N	Diabetes
Y N	Allergies to any Drugs	Y N	Handicaps/Disabilities
Y N	Allergic to Latex/Metals	Y N	Hearing Impairment
Y N	Allergic to Plastic	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia
Y N	Any Operations	Y N	Hepatitis
Y N	Asthma	Y N	HIV+/AIDS
Y N	Cancer	Y N	Kidney/Liver Problems
Y N	Congenital Heart Defect	Y N	Rheumatic/Scarlet Fever
Y N	Convulsions/Epilepsy	Y N	Tuberculosis (TB)

Please list any medical problems that your child has had: _____

_____

_____

_____

Does your child have any of the following habits?

Y N	Clenching/Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking/Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb/Finger Sucking
Y N	Nail Biting	Y N	Tongue Thrust

PARENT AND INSURANCE INFORMATION

Mother's Information

☐ Mother ☐ Step-Mother ☐ Guardian

Name: _____
Birthdate: _____
Work#: _____
Ext. _____
Home#: _____
Email address: _____
Employer: _____

Father's Information

☐ Father ☐ Step-Father ☐ Guardian

Name: _____
Birthdate: _____
Work#: _____
Ext. _____
Home#: _____
Email address: _____
Employer: _____

Person Responsible for Account

Name: _____
Relation: _____
Billing Address: _____
_____
CITY STATE ZIP
Previous Address: _____
_____
CITY STATE ZIP
Work#: _____ Ext.: _____
Home#: _____
Employer: _____

Additional Comments

_____
_____
_____
_____
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_____
_____

Orthodontic Dental Insurance Information

Insurance Company Name: _____
Insurance Company Address: _____
_____
Insurance Company Phone#: _____
Group #: _____
Name of Subscriber: _____
Subscriber's Birthdate: _____
Subscriber's Employment Status: _____
Social Security# / Insurance ID#: _____
Employer's Name: _____
Employer's Address: _____
_____
Employer's Phone#: _____

Thank you for filling out this form completely!

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my understanding that I must notify this office with any changes in child's medical status.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

Our Office is Committed to Meeting and Exceeding the Standards of Infection Control Mandated by OSHA, the CDC, and the ADA.