www.orthoworks.com

DAVID SHEN, D.M.D. & ASSOCIATES
SPECIALISTS IN ORTHODONTICS & INVISALIGN®

CHILD PATIENT INFORMATION

PLEASE PRINT

Patient's Name ______________________ (Last / First / Middle) **Date of Birth** ______ (Month / Day / Year) **M** ___ **F** ___

Address ______________________ (Street / City / Zip Code) **Phone** (____) ________

School ________________ Siblings ________________

Referred By ________________ Patient E-Mail ________________

Dentist ________________ Phone (____) ________

Physician ________________ Phone (____) ________

Mother's Name ________________ (Last / First / Middle) **Father's Name** ________________ (Last / First / Middle)

Social Security Number ________________ Social Security Number ________________

Home Address ________________ Home Address ________________

Phone (____) ________ Home (____) ________ Work or Emergency — Phone (____) ________ Home (____) ________ Work or Emergency

Cell Phone (____) ________ Email ________ — Cell Phone (____) ________ Email ________

Employer ________________ Employer ________________

Work Address ________________ Work Address ________________

Is patient covered by orthodontic insurance? ☐ **Yes** ☐ **No**
If yes, please complete the following information.
IF YOU HAVE COVERAGE FROM MORE THAN ONE COMPANY, PLEASE GIVE ALL INFORMATION FOR EACH COMPANY.

Name of Insurance Company(s) ________ Name of Policyholder(s) ________ Date of Birth ________

Policyholder's Employer(s) ________ Union Local Number(s) ________ Employer Group Number(s) ________

Person Responsible for Account ________________
(If person other than above, please give address, phone and relationship.)

Dental History

Date of last dental care ________________

Family history of orthodontic problems ________________

Were there any habits which might have caused the teeth to move? (i.e. nail or lip biting, thumbsucking, etc.) ________________

Has an orthodontist been consulted previously? ________________

What is your main concern? ________________

	Yes	No
Has there been any injuries to the face, mouth or teeth?	☐	☐
Does the patient have any speech problems?	☐	☐
Are there any missing or extra permanent teeth?	☐	☐

List any musical instruments played by mouth ________________

	Yes	No
Does patient have clenching or grinding habits?	☐	☐
Does patient have sore or sensitive teeth?	☐	☐
Has patient ever had any orthodontic treatment?	☐	☐

ORAL HYGIENE

	Yes	No
Is patient self-conscious about the appearance of his/her teeth?	☐	☐
Has a dentist or hygienist shown patient how to clean his/her teeth?	☐	☐

ORAL HYGIENE *continued*

	Yes	No
Has a dentist or hygienist shown patient how to clean his/her teeth?	☐	☐
Do you still use these methods?	☐	☐

How often does patient brush his/her teeth? ________________

List type of toothbrush (hard, med, soft) ________________

List any other aids (i.e. floss, stimudent, water spray device, rubber tip, toothpick) and how often used ________________

When was the last professional dental cleaning? ________________

How often scheduled? ________________

Additional general dental information: ________________

Medical History

Date of last medical care ______________________

Has your child been a patient in a hospital in the past 2 years? ☐ Yes ☐ No Reason: ______________________

Health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do any of the following pertain to your child? Please check yes or no to each.

	Yes	No
1. Allergies	☐	☐
a. Penicillin or other Antibiotics	☐	☐
b. Local anesthetic	☐	☐
c. Metal	☐	☐
d. Latex	☐	☐
e. Others	☐	☐
2. Arthritis	☐	☐
3. Asthma	☐	☐
4. Blood Disease or Abnormal Bleeding Problems	☐	☐
a. Anemia	☐	☐
b. Clotting problems	☐	☐
c. Excessive Bleeding requiring Treatment	☐	☐
d. Other Blood Disorders	☐	☐
5. Chest Pains, Ankle Swelling or Shortness of Breath	☐	☐
6. Diabetes	☐	☐
a. Occurrence in Immediate Family	☐	☐
7. Epilepsy	☐	☐
8. Fainting	☐	☐
9. Glandular Disease (thyroid, etc.)	☐	☐
10. Heart Disease	☐	☐
11. Heart Murmur	☐	☐
12. Rheumatic Fever	☐	☐
13. High Blood Pressure	☐	☐
14. Low Blood Pressure	☐	☐
15. Kidney Disease	☐	☐
16. Liver Disease, Hepatitis, Jaundice	☐	☐
17. Psychiatric Treatment	☐	☐
18. Radiation Treatment	☐	☐
19. Respiratory Disease	☐	☐
20. Stomach or Duodenal Ulcers	☐	☐
21. Tumor History	☐	☐
22. Venereal Disease	☐	☐
23. A.I.D.S./HIV +	☐	☐
24. Joint Replacement	☐	☐
25. Phen-Fen or Diet Drugs	☐	☐
26. Bisphosphonates	☐	☐

27. Other medical concerns: ______________________

	Yes	No
28. Is patient taking medicine, drugs or pills regularly?	☐	☐
29. Does patient require pre-medication with antibiotics prior to dental treatment (based on physician's instruction)?	☐	☐
30. Has patient experienced any unfavorable reaction to previous dental treatment?	☐	☐

28\. If so, name medication(s) ______________________

29\. If so, name of medication ______________________

30\. If so, please explain particulars ______________________

Please explain any particulars if any "yes" answers were given above: ______________________

____

____

____

____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or his nurse or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay for them. OrthoWorks Dental Corporation may run a credit report on me and/or my guarantor.

I authorize assignment of insurance benefits payable to OrthoWorks.

Signed ______________________ Date ______________
Patient, Parent or Agent (Must be 18 years or older)

There is no change, to my personal knowledge, on my medical history. Medical History Reviewed:

Date: ________ Initial: ______ Date: ________ Initial: ______ Date: ________ Initial: ______ Date: ________ Initial: ______