

**Welcome to Dr. Aaron Rondon's Office!**

**CHILD PATIENT INFORMATION**

DATE: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female I prefer to be called: \_\_\_\_\_

SSN: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_ Cell number: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Attends school at: \_\_\_\_\_ Grade: \_\_\_\_\_ If Musical Instruments Played: \_\_\_\_\_

Sports and/or Hobbies: \_\_\_\_\_

Names of brothers and sisters: \_\_\_\_\_ Ages: \_\_\_\_\_

Other family members treated here: \_\_\_\_\_

Email address: \_\_\_\_\_ General Dentist Name \_\_\_\_\_ Last Visit: \_\_\_\_\_

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

**RESPONSIBLE PARTY INFORMATION**

Who is financially responsible for this account? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Residence (if different from patient's): \_\_\_\_\_

Street City State Zip

Mailing Address: \_\_\_\_\_

Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SSN #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_

Spouse's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ Birth Date.: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance coverage for dental treatment?  Yes  No Insurance coverage for orthodontic treatment?  Yes  No

Primary Policy Holder's Name: \_\_\_\_\_ SSN/SIN: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed by: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Local #: \_\_\_\_\_

Secondary Policy Holder's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed by: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Local #: \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Street City State Zip

Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

For the following questions mark yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

**PATIENT PROFILE**

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self conscious about teeth?

**MEDICAL HISTORY**

**Now or in the past, have you had:**

- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Heart murmur?
- yes no dk/u Frequent headaches, colds, or sore throats?
- yes no dk/u Eye ear, nose or throat condition?
- yes no dk/u Hay fever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adenoid conditions?

**GIRLS ONLY**

- yes no dk/u Has the patient started her monthly periods?  
If so, approximately when? \_\_\_\_\_
- yes no dk/u Is the patient pregnant?

**ALLERGIES / REACTIONS TO ANY OF THE FOLLOWING:**

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- yes no dk/u Ibuprofen (Motrin, Advil) or Aspirin
- yes no dk/u Penicillin or other antibiotics or sufa

- yes no dk/u Codeine or other narcotics
- yes no dk/u Latex (gloves, balloons) or metals
- yes no dk/u Do you chew or smoke tobacco?

**DENTAL HISTORY**

**Now or in the past have you had:**

- yes no dk/u Permanent or "extra" teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u Jaw fractures, cysts or mouth infections?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u History of speech problems?
- yes no dk/u Thumb, finger or sucking habit?  
Until what age? \_\_\_\_\_
- yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
- yes no dk/u Tooth grinding or jaw clenching?
- yes no dk/u Any pain, clicking or locking in jaw or ringing in the ears?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any wisdom teeth problems?
- yes no dk/u Had periodontal (gum) treatment?
- yes no dk/u Been under another dentist's care?

Specialist \_\_\_\_\_

- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: \_\_\_\_\_ Floss: \_\_\_\_\_

What is your primary concern? Why are you here? \_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

1. \_\_\_\_\_ I authorize release of any information leading to insurance claims for this patient and authorize payment directly to Rondon Dental Corp., of the group insurance benefits.
2. \_\_\_\_\_ I realize that a credit report may be necessary in determining a payment plan for the Orthodontic treatment.
3. \_\_\_\_\_ The parent or guardian who accompanies the child is responsible for payment unless other arrangements have been made.

**Parent or Guardian Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Staff Member Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**MEDICAL HISTORY UPDATE OR CHANGES** (For office use only)

**Comments:** \_\_\_\_\_

**Staff Member Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_