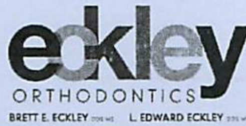
Welcome to our office!



Come smile with us!

TELL US ABOUT YOUR CHILD

Today's Date: ______________________ Nickname: ______________________ ❑ Male ❑ Female

Child's Name: ____
LAST FIRST MIDDLE

Birthdate: ______ / ______ / ______ Age: ______

Child's Home Phone #: ____

Child's Home Address: ____
STREET CITY STATE ZIP

School: ______________________________________ Grade: __________

Hobbies/Sports: ____

Who is accompanying your child today?

Name: ______________________________ Relationship: ______________________

Whom may we thank for referring you to our office: ______________________________

Name and ages of other children in family: ______________________________

____

List any family members who have been or are in treatment in our office: ______________________

____

Parent's Marital Status (circle one): Single Partnered Divorced Married Separated Widowed

Mother's Information

Name: ______________________________ Birthdate: _____ / _____ / _____

Address: ____

Home #: ______________ Work #: ______________ Cell #: ______________

SSN# : ______________________ Email: ______________________

Employer: ______________ Occupation: ______________ Length of Service: ________

Orthodontic Insurance (circle) Y N Insurance Company: ______________________

Father's Information

Name: ______________________________ Birthdate: _____ / _____ / _____

Address: ____

Home #: ______________ Work #: ______________ Cell #: ______________

SSN# : ______________________ Email: ______________________

Employer: ______________ Occupation: ______________ Length of Service: ________

Orthodontic Insurance (circle) Y N Insurance Company: ______________________

Stepmother/Guardian Information

Name: ______________________________ Birthdate: _____ / _____ / _____

Address: ____

Home #: ______________ Work #: ______________ Cell #: ______________

SSN# : ______________________ Email: ______________________

Employer: ______________ Occupation: ______________ Length of Service: ________

Orthodontic Insurance (circle) Y N Insurance Company: ______________________

Stepfather/Guardian Information

Name: ______________________________ Birthdate: _____ / _____ / _____

Address: ____

Home #: ______________ Work #: ______________ Cell #: ______________

SSN# : ______________________ Email: ______________________

Employer: ______________ Occupation: ______________ Length of Service: ________

Orthodontic Insurance (circle) Y N Insurance Company: ______________________

eckley ORTHODONTICS
BRETT E. ECKLEY L. EDWARD ECKLEY

What main concerns do you want to address with orthodontic treatment? ______

Has your child ever been evaluated or had orthodontic treatment before? Yes No
Describe if Yes: ______

Name of patient's general dentist: ______ Date of last visit: ______
Does your child require antibiotic premedication before dental procedures? Yes No
Has your child ever experienced any of the following?

Y	N	Clenching/Grinding	Y	N	Nail Biting	Y	N	Thumb / Finger Sucking
Y	N	Tongue Thurst	Y	N	Nursing/Bottle Habit			Until what age: ______
Y	N	Lip Sucking / Biting	Y	N	Speech Problems	Y	N	Pacifier Habit
Y	N	Mouth Breathing						Until what age: ______

Does your child experience frequent headaches? Yes No
Have there been any injuries to the face, mouth, teeth or chin? Yes No
Describe if Yes: ______
List any musical instruments played: ______
Has your child been informed of any missing, impacted or extra permanent teeth? Yes No
Describe if Yes: ______
Has your child had any pain / tenderness in his/her jaw joint (TMJ/ MD), ears, temples or cheeks? Yes No
Describe if Yes: ______

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

Y	N	Abnormal Bleeding	Y	N	Cancer/Tumor	Y	N	Hearing Impairment	Y	N	Rheumatic/Scarlet Fever
Y	N	Hemophilia	Y	N	Diabetes	Y	N	Heart Murmur/Heart Problems	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Epilepsy/Convulsions	Y	N	Tuberculosis	Y	N	Tonsillitis/Adenoiditis
Y	N	Blood Disease	Y	N	Endocrine Problems	Y	N	Hepatitis/Jaundice	Y	N	Tonsils Removed Age: ______
Y	N	HIV/Aids	Y	N	Asthma	Y	N	Herpes			
Y	N	Arthritis/Bone Disorder				Y	N	Kidney/Liver Problems	Y	N	Adenoids Removed Age: ______
Y	N	Are you or could you be pregnant									
									Y	N	Do you smoke or use tobacco products

If answered yes to any of the above, please explain: ______

Child's Physician: ______ Phone: ______ Date of last visit: ______
Is your child under the care if a physician? Yes No If yes, explain: ______

Please list all drugs/materials your child is allergic or sensitive to (e.g. nickel) : ______

EMERGENCY INFORMATION

Name of nearest relative not living with you: ______
Relationship to patient: ______ Home Phone: ______ Cell Phone: ______
Address: ______
STREET CITY STATE ZIP

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services, including x-rays, my child may need.

______ ______
Signature of Parent of Guardian Date