



Welcome

Patient Information • Child or Teen

Patient's Name _____ Age _____ Birth Date _____

Nickname (if preferred) _____ Male Female Patient's Home Phone # _____

Patient's Home Address _____
Street City State Zip

Who is accompanying the child today? Name _____
First Middle Last

Relationship _____ Do you have legal custody? YES NO Email Address _____

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO • If YES, Name _____
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? YES NO • If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to Kelly M Giannetti, DMD, MPH, MS. I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

Dental and Medical History

Is the child currently under the care of a physician? YES NO • If YES, for what reason? _____

Child's Physician _____ Phone # _____

History of major illness? YES NO • If YES, please describe _____

Any sensitivities or allergies? YES NO • If YES, please list _____

Currently taking any medications? YES NO • If YES, please list _____ Amount/Dose _____

Continued on back

Orthodontic Specialist
Kelly M Giannetti
— DMD, MPH, MS, APC —

Has puberty begun? YES NO

Has menstruation (period) begun? YES NO NOT APPLICABLE

Has the child been treated for any of the following?

- Arthritis
- Blood Disorder
- Diabetes
- Heart Condition
- Tuberculosis
- Asthma
- Cancer
- Epilepsy
- Nervous Disorders

Does the child require antibiotics before dental treatment? YES NO • If YES, explain _____

Have the adenoids or tonsils been removed? YES NO

Have you been informed of any missing or extra permanent teeth? YES NO

Have there been injuries to the child's face, mouth or chin? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? YES NO

Does or did your child have any of the following habits?

- Grinding Teeth
- Finger/Thumb Sucking
- Prolonged Bottle/Pacifier
- Mouth Breather
- Speech Problems
- Chewing/Eating Problems

Parents Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Parent

Father Mother Domestic Partner Guardian Name _____
First Middle Last

Address (if different than child's) _____
Street City State Zip Birth date _____

Home # _____ Work # _____ Cell # _____ SS# _____

Email Address _____ @ _____

Employer _____ Employer's Address _____ Employer's # _____
Street City State Zip

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____
Street City State Zip

Parent

Father Mother Domestic Partner Guardian Name _____
First Middle Last

Address (if different than child's) _____
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