

WELCOME TO DR. INGRAHAM'S OFFICE

A B C

Child's Information

Whom may we thank for referring you to our office? _____ Date _____

Child's Full Legal Name _____ Male Female Nickname _____

Address _____
Street City State Zip

Home Phone _____ Birth-date ____/____/____ Who is with child today? Parent(s) Step-parent _____

The Parent or Guardian who accompanies the child is responsible for payment.

Father's Information

Father Step-father _____

Marital Status: Single Married Divorced Widower

Full Legal Name _____

Residence _____
Street Address

City, State, Zip

Mailing Address _____
(if different from above)

How long at this residence? _____

Previous Address: _____
(if less than 3 years) Street Address

City, State, Zip

Home Phone: _____ Work Phone: _____

Employer: _____
(Name of business if self-employed)

Occupation: _____ No. years at Employer: _____

Social Security Number: _____ Birthdate: ____/____/____

Mother's Information

Mother Step-mother _____

Marital Status: Single Married Divorced Widow

Full Legal Name _____

Residence _____
If different from father: Street Address

City, State, Zip

Mailing Address _____
(if different from above)

How long at this residence? _____

Previous Address: _____
(if less than 3 years) Street Address

City, State, Zip

Home Phone: _____ Work Phone: _____

Employer: _____
(Name of business if self-employed)

Occupation: _____ No. years at Employer: _____

Social Security Number: _____ Birthdate: ____/____/____

If Applicable: Father Mother

Active Duty Retirement or Rotation Date _____

Military Information: Rank/Rate _____ Duty Station _____

Insurance Information

Primary Insurance		Secondary Insurance	
Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Person's Name under which child has coverage: _____		Person's Name under which child has coverage: _____	
Employer: _____		Employer: _____	

Please allow us to make a copy of your insurance card.

Emergency Information

Name of nearest relative not living with you _____

Complete Address: _____
Street City State Zip Code

Phone Number: (____) _____

This office reserves the right to verify the credit status of parents of potential patients prior to setting up financial arrangements.

Signature of parent or guardian _____ Date _____

Update (date & initial) _____ Update (date & initial) _____

Child's Name _____ Age _____ Grade _____
 Musical Instrument(s) currently playing _____ School _____
 Personal Interests or Hobbies _____
 Name & Ages of Siblings _____

Dental History

Child's Dentist _____
 Date of Last exam _____
 Has child been to an orthodontist before? Yes No
 Have other family members had orthodontic treatment?
 Yes No
 What are the main concerns you have about your child's
 teeth? _____

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Does/did your child suck thumb/finger? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child suck/bite lip? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child breathe through mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had serious injury to the face, mouth, or teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does/did child have missing/extra teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child clench/grind teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have pain when opening or closing mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has child had a negative reaction to dental or medical care? |

Medical History

Medical Doctor _____ Last Exam _____
 Under care of doctor now? Yes No
 Medications being taken now: _____

 Has your child experienced ?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment?
<input type="checkbox"/>	<input type="checkbox"/>	Allergic to latex/metals?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis?
<input type="checkbox"/>	<input type="checkbox"/>	Allergic to plastic?	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS?
<input type="checkbox"/>	<input type="checkbox"/>	Any operations?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems?
<input type="checkbox"/>	<input type="checkbox"/>	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever?
<input type="checkbox"/>	<input type="checkbox"/>	Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis?
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect?

Is antibiotic premedication required before dental procedure? Yes No
 Allergies: _____
 Please discuss any medical problems that your child has that might have an effect on his/her treatment in our office:

 For growth purposes, has your child gone through puberty?
 Yes No Just beginning

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

History given by: _____ Signature _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient.

Initials _____ Date _____

Comments: _____

MEDICAL HISTORY UPDATE

I have reviewed my child's dental and medical history and confirm that it is current and complete.

 Signature _____ Date _____

 Signature _____ Date _____

 Signature _____ Date _____