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 Military Information: Rank/Rate ______ Duty Station ______ Retirement or Rotation Date ______

Insurance Information

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Orthodontic Coverage? ☐ Yes ☐ No ☐ Don't know

Person's Name under which child has coverage: ______

Employer: ______

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Orthodontic Coverage? ☐ Yes ☐ No ☐ Don't know

Person's Name under which child has coverage: ______

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	
☐	☐	Does/did your child suck thumb/finger?
☐	☐	Does your child suck/bite lip?
☐	☐	Does your child breathe through mouth?
☐	☐	Does your child have speech problems?
☐	☐	Has your child had serious injury to the face, mouth, or teeth?
☐	☐	Does/did child have missing/extra teeth?
☐	☐	Does child clench/grind teeth?
☐	☐	Does child have headaches?
☐	☐	Does child have pain when opening or closing mouth?
☐	☐	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	
☐	☐	Blood Disorders?	☐	☐	Diabetes?
☐	☐	Drug Allergies?	☐	☐	Hearing Impairment?
☐	☐	Allergic to latex/metals?	☐	☐	Hepatitis?
☐	☐	Allergic to plastic?	☐	☐	HIV / AIDS?
☐	☐	Any operations?	☐	☐	Kidney/Liver Problems?
☐	☐	Asthma?	☐	☐	Rheumatic/Scarlet Fever?
☐	☐	Cancer?	☐	☐	Tuberculosis?
☐	☐	Convulsions/Epilepsy?	☐	☐	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