W. NETTLES GREEN, D.M.D., M.S.

WELCOME TO OUR OFFICE

- Please Print -

DATE OF BIRTH ____________ DATE ____________

Patient's Name ______________________________ Age ______ Sex: Male ☐ Female ☐

First Middle Last

Name Patient Prefers to be Called ______________________ Telephone Number ____________

Home Address ______________________________ Zip Code ____________

School ______________________________ Grade ____________

Patient's Hobbies or Interests ______________________________

Patient's Dentist ______________________ Date of Last Visit ____________

IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.) ______________________________

Father's Name ______________________ Date of Birth ____________

Employed by ______________________ Business Telephone ____________

Father's Dental Insurance ______________________ Soc. Sec. No. ____________

Insurance Address ______________________ Insurance Telephone ____________

Mother's Name ______________________ Date of Birth ____________

Employed by ______________________ Business Telephone ____________

Mother's Dental Insurance ______________________ Soc. Sec. No. ____________

Insurance Address ______________________ Insurance Telephone ____________

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐

Email Address ______________________

Responsible party's email address ______________________________

Names and Ages of Other Children in Family ______________________________

Please list any Family Members previously treated here ______________________________

Is the patient under the care of a physician for a specific problem at the present time? Yes ☐ No ☐ Illness ____________

List any medicines your child is currently taking ______________________________

List any drug allergies ______________________________

Is there a history of serious illness, accident or operation? ______________________________

If so, list. ______________________ Physician/Pediatrician ____________

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Bone Disorder	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ HIV/Aids	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble/Disease	☐ Tonsilitis	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders
☐ Hepatitis/Liver Disease	☐ Ear Infections	☐ Epilepsy	☐ Adopted

Has the patient reached puberty?

Girls: Has she started menstruation? Yes ☐ No ☐ If yes, Month/Year ____________

Boys: Has his voice changed? Yes ☐ No ☐

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? ______________________ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? ______________________ ☐ Yes ☐ No

Until what age? ____________

Has an orthodontist been consulted previously? ______________________ ☐ Yes ☐ No

Has the patient had any previous orthodontic treatment? ______________________ ☐ Yes ☐ No

If so, by whom? ______________________

Have you been informed of any missing or extra permanent teeth? ______________________ ☐ Yes ☐ No

What part of your child's orthodontic problem concerns you most? ______________________________

____

Additional information which you feel would help make your child's association with us more enjoyable. ____________

____

THANK YOU

Member
American Association of
Orthodontists

____
Signature of Parent or Guardian