

**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

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**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Bone Disorder           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Speech Problems    |
| <input type="checkbox"/> HIV/Aids                | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble/Disease   | <input type="checkbox"/> Tonsillitis           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Hearing Disorder      | <input type="checkbox"/> Bleeding Problems   | <input type="checkbox"/> Nervous Disorders  |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Ear Infections        | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> 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