



Welcome to the office of Dr. Noelle Williams

Child Patient Form

Patient's Name : _____ Nickname: _____
 Birthdate: _____ Male Female Home phone: _____
 Home Address: _____ City: _____ State: _____ Zip code: _____
 Special interests, sports or hobbies: _____
 Patient's Dentist: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Whom may we thank for this referral? Dentist: (name) _____
 Friends: (name) _____ Friends: (name) _____
 Friends: (name) _____ Other: (name) _____
 Family members who have been patients: (name & relationship) _____
 Name of person accompanying child today: _____ Relationship: _____
 Parents' Marital Status: Married Single Widowed Divorced Separated
 If remarried, spouse's name: _____

SIBLING'S

Name	Date of Birth	Sex	Name	Date of Birth	Sex
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

PARENT'S INFORMATION

Mother's Name: _____ Social Security#: _____
 Address: (if different) _____
 Home Phone: _____ Cell: _____ E-mail: _____
 Employer: _____ Present Position: _____
 Business Address: _____ Business Phone: _____ Ext: _____

 Father's Name: _____ Social Security#: _____
 Address: (if different) _____
 Home Phone: _____ Cell: _____ E-mail: _____
 Employer: _____ Present Position: _____
 Business Address: _____ Business Phone: _____ Ext: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT THAN ABOVE)

Name: _____ Social Security#: _____
 Address: (if different) _____
 Home Phone: _____ Cell: _____ E-mail: _____
 Employer: _____ Present Position: _____
 Business Address: _____ Business Phone: _____ Ext: _____

Welcome to the office of Dr. Noelle Williams

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone: _____
 Group# (Plan, Local, or Policy#): _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's Birthday: _____ SS#: _____
 Insured's Employer: _____
 Orthodontic Coverage? Yes No
 Name of Physician: _____
 Address: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone: _____
 Group# (Plan, Local, or Policy#): _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's Birthday: _____ SS#: _____
 Insured's Employer: _____
 Orthodontic Coverage? Yes No
 Phone: _____
 City: _____ State: _____ Zip code: _____

MEDICAL HISTORY

<p>Please Circle</p> <p>Y N Heart Murmur/Congenital Defect</p> <p>Y N Diabetes</p> <p>Y N Rheumatic Fever</p> <p>Y N Cancer</p> <p>Y N HIV +/- AIDS</p> <p>Y N Hemophilia</p> <p>Y N Blood Transfusions</p> <p>Y N Asthma</p> <p>Y N Hepatitis</p> <p>Y N Tuberculosis</p> <p>Y N Heart Problems</p> <p>Y N Sinus Problems</p>	<p>Please Circle</p> <p>Y N High Blood Pressure</p> <p>Y N Convulsions/Epilepsy</p> <p>Y N Abdominal Bleeding</p> <p>Y N Hearing Impairment</p> <p>Y N Operations/Stays in a Hospital</p> <p>Y N Kidney/Liver Problems</p> <p>Y N Handicaps/Disabilities</p> <p>Y N Allergies to Drugs</p> <p>Y N Antibiotics Prior to Dental Treatment</p> <p>Y N Other Medical Conditions</p> <p>Y N Medications</p>
--	--

If you have circled Yes for any of the above, please explain: _____

DENTAL HISTORY

Y N Injuries to Face/Teeth	Y N Unfavorable Dental Experience	Y N Speech Problems
Y N Other Orthodontic Treatment	Y N Missing Teeth	Y N Mouth Breathing
Y N Pain/Noises in the Jaw Joint (TMJ)	Y N Extra Teeth	Y N Gums Bleed
Y N Root Resorption	Y N Finger Sucking	Y N Grind Teeth
Y N Periodontal Disease	Y N Tongue Thrusting	

If you have circled Yes for any of the above, please explain: _____

What do you see as the main problem with your teeth? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

 Signature

 Date

Thank you for completing this form. It will enable us to treat you more effectively. If you have questions at any time, please ask us. We are happy to help.