COHEN ORTHODONTICS

American Association of Orthodontists®

Member American Association of **Orthodontists**

Orthodontics for Adults & Children
Oro-facial Orthopedics
TM Dysfunction

TO OUR NEW PATIENTS:
Your kindness in furnishing the following information will be appreciated in preparing your child's clinical chart.

"Please Print"

Patients's Name _____ (Goes By) _____ Age: ____

Address _____ Male _____ Female _____ Date of Birth: _____

_____ Home Phone ( ) _____

City State ZIP Family E-mail _____

Orthodontic Insurance Coverage? Yes _____ No _____ Carrier Name / ID Number _____

Secondary Insurance Coverage? Yes _____ No _____ Carrier Name / ID Number _____

Patient's Dentist _____ Patient Referred By _____ School _____

Names/ages of sisters and/or brothers treated here _____

Father's Name _____ Mother's Name _____

Date of Birth _____ Date of Birth _____

Address _____ Address _____

_____ _____

City State ZIP City State ZIP

Phone: Home ( ) _____ Phone: Home ( ) _____

Business ( ) _____ Business ( ) _____

Cell ( ) _____ Cell ( ) _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Parent's Marital Status _____ Is either parent deceased? _____

Father's Dentist _____ Mother's Dentist _____

Responsible party if different from above: Nearest relative not living with you:

Name _____ Name _____

Address _____ Address _____

_____ _____

City State ZIP City State ZIP

A B C L-8

CHILD MEDICAL HISTORY

1. Who is your child's physician? _____ Date of last physical exam? _____

   Physician's Address _____ Physician's Phone No. _____

2. Has there been any change in your child's health within the past year? _____

3. Is your child being treated by a physician for any reason at present? _____

4. What medicine(s) is your child taking now? _____

5. Has your child ever been hospitalized for any illness, accident or surgery? _____

   If yes, when and why? _____

Does your child have or has he/she had any of the following:	YES (CHECK ✓)	NO
6. Heart Trouble (including heart murmurs, valve prosthesis/pacemaker)		
7. Rheumatic fever		
8. High/low blood pressure		
9. Kidney problems		
10 Liver disease (hepatitis)		
11. Jaundice		
12. Diabetes		
13. Anemia, Sickle Cell, Iron Deficiency, Etc.		
14. Prolonged bleeding		
15. Severe Infections		
16. Epilepsy		
17. Fainting		
18. Convulsions		
19. Pneumonia		
20. Tuberculosis		
21. Venereal Disease		
22. AIDS or HIV positive		
23. Arthritis		

	YES	NO
24. Osteoporosis		
25. Allergy, hay fever, hives		
26. Asthma		
27. Sinus Problems		

Is your child allergic to or has he/she had any unusual reactions to:	YES	NO	UNKNOWN
28. Penicillin			
29. Dental local anesthetics			
30. Barbiturates			
31. Codeine or other narcotics			
32. Aspirin			
33. Sedatives			
34. Sulfa			
35. Latex (gloves, balloons)			
36. Nickel			
37. Any other drugs Medicines (Specify)			
38. Does your child have any other disease, condition or emotional problems you would like to bring to our attention?			

CHILD DENTAL HISTORY

What is your reason for bringing your child here?_____

_____

_____

1. Date of last dental visit _____

2. Treatment at last visit _____

		YES (CHECK ✓)	NO
3. Has your child experienced any dental pain?			
4. Has your child had an unhappy	a. medical visit		
	b. dental visit?		
5. Any injuries to teeth, mouth or head?			
6. Does your child have bleeding gums?			
7. Does your child have frequent mouth ulcers or cold sores?			
8. Did your child take a bottle to bed at nap or bed time?			
9. Any oral habits: thumbsucking, nailbiting, mouthbreathing?			

If yes, specify: _____

10. What is your child's attitude toward dentistry and/or orthodontics?_____

_____

Additional comments _____

_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____ _____

I give my consent for the initial examination at no charge.

Signature _____ Date _____