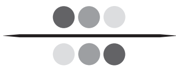

DR. JULIANNE C. PETERSON DDS, MSC **certified specialist in orthodontics**

New Patient Information - Child

Child's name: ______________________ (last / first / middle) Nickname or preferred name: ______________________

Birthdate: ____________ (mm/dd/year) Age:_____ ○ M ○ F Home phone number: ______________________

Address: ______________________ (number / street / city / province / postal code)

Mother's name: ______________________ Phone number: ____________ Home

Address: ______________________ (number / street / city / province) ____________ Work

E-mail address: ______________________ ____________ Cell

Father's name: ______________________ Phone number: ____________ Home

Address: ______________________ (number / street / city / province) ____________ Work

E-mail address: ______________________ ____________ Cell

Siblings' name(s): ______________________

Who will be responsible for this account? ○ Self ○ Parents ○ Father ○ Mother ○ Other

Responsible party name: Mr / Mrs / Ms / Dr ______________________

Responsible party address ○ Same as above OR ______________________

Phone: Home: ______________________ Work: ______________________

Cell: ______________________ E-mail address: ______________________

Do you have any other family members we have treated in our office? ○ Yes ○ No

Names: ______________________ ______________________

Were you referred by your family dentist? ○ Yes ○ No Name: ______________________

Were you referred by someone else? ○ Yes ○ No Name: ______________________

Dental History

Dentist: ______________________ Last dental check-up: ______________________

How often does your child brush their teeth? ______________________ Do they floss daily? ○ Yes ○ No

Does/did your child have a history of the following?

○ Clenching/grinding
○ Clicking/pain in jaw joint
○ Difficulty chewing/swallowing
○ Injuries to face/mouth/teeth
○ Tonsils/adenoids removed
○ Lip sucking/biting
○ Mouth breathing
○ Nail biting
○ Smoking
○ Speech problems
○ Tendency to colds, sore throats, ear infections
○ Tongue thrust
○ Thumb/finger sucking
○ Other: ______________________

List any sports, hobbies, musical instruments played: ______________________

Has your child had previous orthodontic treatment? ○ Yes ○ No

Child's attitude towards orthodontic treatment: ○ Eager ○ Willing ○ Apprehensive ○ Unwilling

Has anyone else in family had orthodontic treatment? ○ Yes ○ No

What would you like treatment to address? ______________________

Medical History

Doctor's name: ____________________

Is your child currently under the care of a physician? ○ Yes ○ No

Are immunizations current? ○ Yes ○ No

Does your child require antibiotics before dental treatment? ○ Yes ○ No

Do you wish to speak to the doctor in private? ○ Yes ○ No

Has your child reached puberty? ○ Yes ○ No

Is your child currently pregnant? ○ Yes ○ No

How is your child's current physical health? ○ Good ○ Fair ○ Poor

Please list current medications and reason for taking ____________________

____

Has your child had or experienced any of the following?

- ○ Allergies (including metals and latex)
- ○ Asthma
- ○ Bone disorders
- ○ Cancer
- ○ Congenital heart defect
- ○ Diabetes
- ○ Prosthetic/artificial joints
- ○ Arthritis
- ○ Drug or alcohol abuse
- ○ Emotional problems
- ○ Endocrine problems
- ○ Epilepsy
- ○ Hearing/vision impairment
- ○ Heart disease
- ○ Rheumatic fever
- ○ Blood pressure - high or low
- ○ Heart murmur
- ○ Hemophilia/bleeding disorder
- ○ Hepatitis
- ○ HIV/AIDS
- ○ Kidney problems
- ○ Sinus problems
- ○ Tuberculosis
- ○ Other: ____________________

Authorization

To the best of my knowledge, all of the answers are correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice.
If I have any change in health/medications that are not mentioned above, I will inform the doctor at my next visit.

____________________ initials

____________________ date

____________________ orthodontist's signature

____________________ date

Privacy information

We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

I agree that Dr. J. Peterson and/or members or her staff permission to release information concerning my dental/orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

Signature: ____________________ Date: ____________________

Review Dates

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Doctor's Notes

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