GROVE ORTHODONTICS

WELCOME !

Tell us about your child

Today's date ____________ email address ________________________ Gender M F

Child's Name ___________________________ Nickname ____________________ Date of birth _____________
Last First MI Preferred name

School ____________________ Grade _____ Parents home phone # ____________ Cell _______________

Child's Home address ____
Address Apt City

WHO IS WITH THE CHILD TODAY

Name _____________________ Relation _____________ Do you have legal custody of this child? **Yes** **No**

Who may we thank for referring you? ________________ Family members being seen by us _______________

CHILD'S DENTIST

Name ___________________ Address _____________________ Phone __________ Last visit ____________

MOTHER'S INFORMATION

Name ___________________ Address ____________________ City ____________ State ___ Zip _________

Employer __________________ SS# ___________________ Cell # _____________ Home # ____________
Responsible for Account? **Yes** **No** Responsible for making appointments **Yes** **No** (circle) Single Married Divorced

FATHER'S INFORMATION

Name ___________________ Address ____________________ City ____________ State ___ Zip _________

Employer __________________ SS# ___________________ Cell # ____________ Home # _____________
Responsible for Account? **Yes** **No** Responsible for making appointments **Yes** **No** (circle) Single Married Divorced

OTHER RESPONSIBLE PARTY

Name ___________________ Address ____________________ City ____________ State ___ Zip _________

Employer __________________ SS #___________________ Cell # ____________ Home # _____________
Responsible for Account? **Yes** **No** Responsible for making appointments **Yes** **No** (circle) Single Married Divorced

PRIMARY DENTAL INSURANCE

Insurance Co. Name _________________ Address _________________ City __________ State ___ Zip _____

Phone # _________ **Insured's ID #** ________________Group/Policy # _____________ Ortho Coverage **Yes** **No**

Insured's Name _______________ Relationship to Patient ________ Insured's DOB _________ SS#__________

Insured's Employer:

SECONDARY DENTAL INSURANCE

Insurance Co. Name _________________ Address _________________ City __________ State ___ Zip _____

Phone # _________ **Insured's ID #** ________________Group/Policy # _____________ Ortho Coverage **Yes** **No**

Insured's Name _______________ Relationship to Patient ________ Insured's DOB _________ SS#__________

Insured's Employer:

Tell us why you are bringing your child in to see us today.

Tell us about your child's medical health

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1 When was the last visit to your child's physician ___________ **PHYSICIAN** ____________________

Reason?

Still under treatment Yes No

If yes, describe:

2 Does your child currently take any regular medications Yes No

If yes, please list condition and medication

3 Does your child regularly take vitamins or supplements Yes No

4 Does this child have any allergies or asthma (list below) Yes No

5 Does your child breath through his/her mouth, leave mouth open Yes No

6 Does your child have trouble breathing through his/her nose Yes No

7 Is your child often sick with colds, sore throat or ear infections Yes No

8 Has your child had general anesthesia ("put to sleep") Yes No

If yes, please list reason:

9 Has your child been involved in a traumatic accident Yes No

If yes, please describe: head, jaw, limbs, etc.

Please inform us of any conditions that your child may have had or currently has:

Respiratory Disorders: (eg: **Allergies**, **Asthma**, Emphysema, Chronic Hay Fever, Rheumatic Fever)

Cardiovascular: (eg: Heart Murmur, Congenital Heart Defect, High Blood Pressure)

Behavioral/Developmental:(eg: ADD/ADHD, Epilepsy, Seizures, Autism, Cerebral Palsy)

Sensory and/or Speech Impairment: (eg: Eyes, Ears, Hearing or Vision, Stutter, Lisp):

Other: (eg: Hepatitis, Skin Disorders, Diabetes, Blood Diseases, Psychiatric, Bone, Muscle)

Any other medical conditions that Dr. Grove should know about?

Pediatric / Adolescent Airway Sleep Questionnaire

While Sleeping, Does Your Child:

Snore often	Yes No
Have heavy or loud breathing	Yes No
Snore loudly	Yes No
Have altered breathing or struggle to breathe	Yes No
Make gasping sounds periodically	Yes No

Does Your Child:

Say he/she are tired quite often	Yes No
Tend to breathe through the mouth during the day	Yes No
Have a dry mouth upon waking up in the morning	Yes No
Occasionally wet the bed	Yes No
Grind his/her teeth while sleeping	Yes No
Have any bite problems or crowded teeth	Yes No
Wake up tired or un-refreshed in the morning	Yes No
Have a problem with daytime sleepiness	Yes No
Have a teacher comment about being tired	Yes No
Have difficulty waking up in the morning	Yes No
Wake up with headaches	Yes No
Have any history of growth problems	Yes No
Complain of restless or achy legs	Yes No
Have arms and/or legs that twitch during sleep	Yes No
Have nightmares (more than one per week)	Yes No

Have an overweight issue:

Weight is_____________

Height is ____________

Any other conditions or symptoms that Dr. Grove should know about ?

Tell us about your child's dental health

1. When was the last visit to your dentist? _______________ Reason? __________________________

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2. Is there any dental work that still needs to be done **Yes** **No**
   If yes, please explain:

3. Has your child ever had a difficult problem associated with dental work **Yes** **No**

4. Does your child have trouble breathing through his/her nose, mainly breathing through his/her mouth? **Yes** **No**

5. Does your child have a tongue thrust or speech difficulty **Yes** **No**

6. When swallowing, does your child have lip and head movement **Yes** **No**

7. Does your child have any pain or discomfort in the jaw joints (TMJ) **Yes** **No**

8. Does your child have clicking or noise in the jaw joints (TMJ) **Yes** **No**

9. Does your child have finger or thumb sucking habits **Yes** **No**

10. Does your child have lip biting or sucking habits **Yes** **No**

11. Does your child have a nail biting habit **Yes** **No**

12. Does your child have extensive fillings or past dental work **Yes** **No**

13. How well does your child brush (circle) Poor Fair Good Excellent

14. Do you think your child needs flossing instructions? **Yes** **No**

15. Is there any additional information we should know If so, please explain below:

Understanding:

I understand the information that I have given on these pages for my child and the Medical Dental Health History is correct to the best of my knowledge and that it will be held in confidence. It is my responsibility to inform this office of any changes in my child's medical and dental status. With my approval, I hereby authorize Dr. Grove and his dental staff to perform the necessary dental/ orthodontic services needed for an orthodontic evaluation.

______________________________ Signature ______________________ Date