Patient No:

1. ***CHILD:* Personal History** **Date:**

Name: Home Phone:

Age: Birth date: Sex: H: W:

Address : City: State: Zip:

Father's Name: S.S. # Cell Number:

Address (If different): City: State: Zip:

Employer: Work Number:

Mother's Name: S.S. # Cell Number:

Address (If different): City: State: Zip:

Employer: Work Number

Responsibility Party Name (if other than parent):

Relationship to patient:

Address (If different): City: State: Zip:

Primary Ins.: Secondary Ins.:

Referred By: Dentist:

Hobbies/Interests:

2. ***DENTAL HISTORY*** School: Grade:

Have there been injuries to: (circle) Face Mouth Teeth Neck

If Yes, explain:

Has patient ever sucked thumb/finger? Until what age?

Does patient have a speech problem?

Is patient a mouth breather?

> **I understand that I, not my insurance company, will be responsible for the entire account and for any expense incurred through the collection of this account. My signature below indicates that I assign all insurance benefits to be paid to Dr. Williams. If diagnostic records are taken, there will be a $295 charge. This is <u>not</u> included in the amount quoted at consultation appointment.**

> **If financing treatment, credit bureau reports may be obtained.**

Responsible Party Signature:

3. ***TO BE COMPLETED BY DOCTOR***

Classification:

Arch Development:

Overbite: % OverJet: mm

Crowded Segments:

Diastema:

Habits:

R			e	d	c	b	a	a	b	c	d	e			L
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			e	d	c	b	a	a	b	c	d	e			

Recommendations: