CHILD

JOSEPH R. GREGG DDS, MSD
ORTHODONTIST

1700 W Smith Valley Rd Suite A-1
Greenwood, IN 46142
317-888-9833

www.greggortho.com

Patient Information

Child's Legal Name:_____ Preferred Name:_____ Male [ ] Female [ ]
Birthdate:_____ Age:_____ Email:_____
Home Address: _____
City: _____ State: _____ Zip: _____
School:_____ Grade: _____ Hobbies/Sports: _____
_____
Siblings (names & ages): _____
Family Dentist:_____ Last Visit: _____ Physician: _____
Whom may we thank for telling you about us? (dentist, friends, family members) _____
_____
Has any member of your family been a patient in our office? Yes [ ] No [ ]
Names: _____
Who will be accompanying your child? _____ Relationship: _____
With whom does the patient live? _____
Parents' Marital Status: Married [ ] Divorced [ ] Widowed [ ] Single [ ] Separated [ ]

	Father / Stepmother	***Mother / Stepfather***
Names		
Address		
City, State, Zip		
SS #	DOB:	DOB:
Drivers License		
Employer		
Home Phone		
Work Phone		
Cell Phone		
Permission to contact at work?		

Is patient covered by orthodontic insurance? Yes [ ] No [ ] If yes, please bring card with you.
Name of insurance _____
Neighbor or relative not living with you: _____
Address & Phone # (In case of emergency): _____
What are the main concerns that you and your child would like orthodontics to accomplish? _____
_____
_____

Health History

Has your child:

ever been evaluated or had orthodontic treatment before Yes [ ] No [ ]

If yes, by whom? _____

ever had any injuries to the face, mouth, teeth, chin Yes [ ] No [ ]

had adenoids or tonsils removed Yes [ ] No [ ]

ever been informed of any missing/extra teeth Yes [ ] No [ ]

ever had any pain/tenderness/clicking in the jaw joint Yes [ ] No [ ]

Does/did your child have any of the following habits:

clenching/grinding teeth (at night) Yes [ ] No [ ]

mouth breather Yes [ ] No [ ]

nail biting Yes [ ] No [ ]

speech problems Yes [ ] No [ ]

tongue thrust Yes [ ] No [ ]

thumb, finger, lip sucking or biting Yes [ ] No [ ]

Does your child brush his/her teeth daily? Yes [ ] No [ ]

Are all vaccinations current? Yes [ ] No [ ]

Is your child in good health? Yes [ ] No [ ]

Has your child had any history of:
(If applicable, please circle)

allergies to latex, plastic or any metals Yes [ ] No [ ]

asthma, tuberculosis (TB), allergies or hay fever Yes [ ] No [ ]

congenital heart defect or heart murmur Yes [ ] No [ ]

convulsions, epilepsy, or siezures Yes [ ] No [ ]

diabetes, kidney or liver problems Yes [ ] No [ ]

hemophilia, hepatitis, HIV+/AIDS Yes [ ] No [ ]

hospital stays or operations Yes [ ] No [ ]

hearing impairment, handicaps, or disabilities Yes [ ] No [ ]

rheumatic or scarlet fever Yes [ ] No [ ]

Has puberty/menstruation begun? Yes [ ] No [ ]

Does your child chew, smoke or use e-cigarettes? Yes [ ] No [ ]

Please discuss any medical problems that your child has/had: _____

_____

Please list all medications your child is currently taking: _____

_____

Please list all medications your child is allergic to: _____

_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the staff to perform the necessary dental services my child may need. I acknowledge that I have received a copy of the Notice of Privacy Practices of the office of Joseph R. Gregg DDS, MSD. I authorize the release of rights to photographs and orthodontic records for the use by Joseph R. Gregg DDS, MSD.

Signature of parent or guardian: _____ ***Date:*** _____

update:

For Office Use Only

Name	***Initial***	***Date***

I verbally reviewed the health information above with the parent/guardian and patient named herein.

Name: _____ **Date:** _____