



Welcome To Our Practice

CHILD PATIENT INFORMATION

Patient's Name _____ Age _____ Birthdate _____
Nickname _____ Male Female
Address _____ City/State _____ Zip _____
Home Phone # _____ Cell Phone # _____
Parent/Guardian Name _____

School Attending _____ Hobbies _____
Siblings in treatment with Kragor Orthodontics _____

Has patient had previous orthodontic consultations? Yes No Previous orthodontic treatment? Yes No
If so, when/where? _____ Doctor's name _____
What is it about your teeth/bite/smile that has brought you to see us? _____
Who may we thank for referring you to Kragor Orthodontics? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relation to Patient _____ Marital Status S / M / W / D
Address _____ City/State _____ Zip _____
Cell Phone _____ Cell Carrier _____ Work Phone _____
Email Address _____

How would you like to receive your Appointment Reminders? Text Message Email Both

Social Security # _____ - _____ - _____ Birthdate _____
Employer _____ Occupation _____

Second Parent Name _____ Relationship to Patient _____
Social Security # _____ - _____ - _____ Birthdate _____
Phone # _____ Work Phone # _____
Employer _____ Occupation _____

Name of nearest relative not living with you _____
Contact # _____ Work # _____
Address _____ City/State _____ Zip _____

DENTAL INFORMATION

Patient's Dentist _____ Patient's Last Dental Visit _____

Has patient had any unfavorable dental experiences? _____

Does the patient currently have, or has the patient ever had any of the following?

Yes No

Thumb / Finger Sucking

Yes No

Nail Biting

Yes No

Missing permanent teeth not due to extraction

Lip Sucking / Lip biting

Nursing/Bottle Habits

Periodontal Disease

MEDICAL INFORMATION

Patient's Overall Health Excellent Good Poor

Is patient currently under the care of a doctor? Yes No. If yes, what for _____

Is patient currently taking any medication? Yes No. If yes, what for? _____

Has patient ever been hospitalized? Yes No. If yes, what for? _____

Does the patient currently have, or has the patient ever had any of the following?

Yes No

Heart Murmur

Yes No

Congenital Heart Def

Yes No

Prosthesis

Yes No

Scarlet Fever Hx

Cancer

Convulsions/Epilepsy

Asthma

Kidney/Liver Problem

Diabetes

Abnormal Bleeding

Hepatitis

Handicap/Disabilities

Rheumatic Fever

Hearing Impairment

Hemophilia

Any Stays in Hospital

HIV / AIDS

Any Operations

Tuberculosis

Allergy to Any Drugs

Please discuss any serious medical conditions the patient has/had _____

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 it is my responsibility to inform this office of any changes in my child's medical status.

Print Parent/Guardian Name

Parent/Guardian Signature

Date

For Office Use Only

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

Signature

Date

Doctor's Comments