Livingston Pediatric Dental Associates
Bansari Shah, DDS
Orthodontics
Specialty # 6224

Patient Information

Patient Name_____ Birthdate ____/____/_____ Age_____ Sex___
Patient Address_____ City_____ State____ Zip_____
Phone_____ Best Daytime Phone _____
Nickname_____ Musical Instruments _____
Hobbies, Sports_____ School_____ Grade_____
Siblings/Ages/Male or Female_____
In your own words, what is the problem? _____
Does anyone else in the family have a similar problem? _____ Who? _____
Are any other family members currently in orthodontic treatment? Y/N Doctor_____
Have any other family members received orthodontic treatment? Y/N Doctor_____
Has your child visited an orthodontist before? Y/N Date of last visit_____
Anything you would like to discuss with the doctor in private? Y/N _____

Responsible Party Information

Parents Marital Status: Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partners ○

Who is responsible for this account? _____

Guardian: Father ○ Step Father ○ Guardian ○ Name_____
Address (if different from child's) _____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ E-Mail _____
Subscriber SSN_____DOB_____

Guardian: Mother ○ Step Mother ○ Guardian ○ Name_____
Address (if different from child's) _____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ E-Mail_____
Subscriber SSN_____DOB_____

Insurance Information: Policy Holder _____
Insurance Company Name_____ Group or Plan #_____
Insurance Company Phone #_____Insurance Company Address_____

Dental History

Current Family Dentist_____ Seen in last 6 months? Y/N
Dentist's Concerns? _____
Does the child require antibiotics before dental treatment? Y/N
Have you been informed of any missing or extra permanent teeth? Y/N_____
Have there been injuries to the child's face, mouth, or chin? _____
Has the child ever had pain/tenderness in the jaw joint? (TMJ/TMD) Y/N_____

Does/Did the child have any of the following habits?

Grinding teeth Thumb/finger habit Prolonged Bottle/Pacifier
Mouth Breather Speech Problems Chewing/ Eating Problems

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Who may we thank for referring you to our practice? _____

Medical History

Physician's Name_____ Phone #_____

Please describe your child's physical health: Good Fair Poor

Is child currently under the care of a physician? Y/N _____

Has child seen a physician in the last 12 months? Y/N _____

Any history of major illnesses? Y/N _____

Has Puberty Begun? Y/N Has Menstruation Begun? (Girls) Y/N

Please list all drugs your child is currently taking: _____

_____

Please list all drugs your child is allergic to: _____

Is there a history of any of the following?

Y N Abnormal Bleeding	Y N Hearing Impairment	Y N Neck aches/ Headaches
Y N Heart Murmur	Y N Kidney Problems	Y N Allergy to Latex/Metals
Y N Speech Problems	Y N Arthritis or Osteoporosis	Y N HIV, HPV or ARC
Y N ADD, ADHD, PDD	Y N Sensory Deprivation	Y N Cancer
Y N Liver Problems/ Hepatitis	Y N Tuberculosis	Y N Developmental Delay
Y N Allergies/ Asthma	Y N Bone Density Issues	Y N Diabetes
Y N Breathing Problems	Y N Thyroid	Y N Allergies to Drugs
Y N Emotional Problems	YN Rheumatic/Scarlet Fever	Y N Other _____

General development of child resembles which parent? Neither parent Father Mother

Father's height _____ inches Mother's height _____ inches

Any problems during pregnancy or birth? _____

Any habits such as nail biting, thumb sucking, lip biting? _____

Did you child have tonsils or adenoids removed? _____

Does your child have any allergies to medications? _____

What drugs does your child take regularly? _____

Does your child desire orthodontic treatment? _____

What do you expect from treatment? _____

To the best of my knowledge, the information I have given on this form is correct and complete. It is my responsibility to inform this office of any changes in my child's health history. I hereby give permission to Dr. Shah to provide orthodontic care to my child. I also give permission for the dental staff to perform the necessary dental services my child may need during treatment.

Signed: _____ Date: _____