BLUESTONE ORTHODONTICS

Date: _____

We are pleased to welcome you and your child to our office!

Please take a few minutes to fill out this form as completely as you can
and make any necessary corrections.

PATIENT INFORMATION

Child's Name: _____ Preferred Name: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Birth date: _____ Sex: _____

School Name: _____ Grade: _____ Hobbies/Interests: _____

Names of brothers and/or sisters: _____ Names of family members treated here: _____

FAMILY INFORMATION

Responsible Party: _____ **Relationship**: _____

Marital Status: (Circle One) Single Married Divorced Widowed

Father's Name: _____	**Mother's Name**: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Home Address: _____ **(**If different than above)	Home Address: _____ **(**If different than above)
City, State, Zip _____	City, State, Zip _____
Father's Social Security #: _____	Mother's Social Security #: _____

Emergency contact not living with patient & relationship: _____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Dentist Name: _____ Approximate date of last visit? _____

Please fill out medical information, employment and insurance information on the back. Thank you!

BLUESTONE ORTHODONTICS

Date: _____

MEDICAL HISTORY

Has your child ever had any of the following? (Check all that apply)

□ Heart Murmur
□ High Blood Pressure
□ Headaches
□ Hepatitis, Jaundice or Liver Disease
□ Nervous Problems
□ Radiation Treatment
□ Recent Weight Loss
□ Back Problems
□ Blood Disease
□ Respiratory Disease
□ Epilepsy
□ Swollen Neck Glands
□ Low Blood Pressure
□ Circulatory Problems
□ Psychiatric Care
□ Mitral Valve Prolapse
□ Allergies to Medicine or Drugs
□ General Allergies
□ Chemical Dependency
□ Arthritis
□ Special Diet
□ Rheumatic Fever
□ Sinus Problems
□ Cancer
□ AIDS/HIV
□ Thyroid Disease
□ Ulcer
□ Diabetes
□ Hemophilia

Does your child have any drug allergies or ever had an adverse reaction to any medication? _____Yes _____No
If so, to what? _____

Has your child ever responded adversely to medical or dental treatment? If yes, explain. _____

_____

Is your child taking any medication at this time? _____ If so, what? _____

Is your child under the care of a physician? _____ If yes, for what condition? _____

Is your (female) child or do you suspect that your (female) child might be pregnant? ____ Yes ____ No
(**This information is requested in the event we need to take an x-ray**)

Is there anything else we should know about your child's medical or dental history? _____

EMPLOYMENT AND INSURANCE INFORMATION

Father Employed By: _____ Occupation: _____

Mother Employed By _____ Occupation: _____

Name of Dental Insurance Company: _____

Name of Insurer: _____

Company's Street Address:
_____

City, State, Zip: _____

Phone number: _____

Insurance Plan ID #: _____ Group #: _____

Insurer's Birth date: _____ Social Security #: _____

Signature: _____ **Date: _____**