CHILD
WELCOME TO DR. FLEER'S OFFICE

DATE____________________

NAME:____ NICKNAME ______________________________

PATIENT'S DENTIST______________________________ DATE OF LAST DENTAL EXAM______________ BIRTHDATE:__________

HOBBIES:____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC CARE:____

REASON FOR CONSULTATION:____

ANY PREVIOUS ORTHODONTIC TREATMENT:____

WHOM DO WE THANK FOR REFERRING YOU TO THIS OFFICE:____________________________________

GENERAL HEALTH:

FAMILY DOCTOR /PEDIATRICIAN________________________________ DATE OF LAST EXAM__________

ANY HISTORY OF (UNDERLINE THE CONDITION)

HEART TROUBLE ALLERGIES DIABETES ASTHMA

KIDNEY OR LIVER INVOLVEMENT EPILEPSY BLEEDING DISORDERS RHEUMATIC FEVER

NOTE CURRENT MEDICATIONS:____

PATIENT'S HEALTH: EXCELLENT GOOD FAIR

ORAL HABITS: FINGER SUCKING NAIL BITING MOUTH BREATHING

LIP OR TONGUE BITING SPEECH PROBLEMS TONGUE THRUSTING

FAMILY INFORMATION:

PATIENT'S ADDRESS:____

PARENT NAME #1______________________________ PARENT NAME #2______________________________

ADDRESS:______________________________ ADDRESS______________________________

OCCUPATION______________ PHONE #__________ OCCUPATION______________ PHONE#__________

HOME PHONE ______________ CELL PHONE #______________ E-MAIL______________________

FATHER'S HEIGHT__________ MOTHER'S HEIGHT__________

BROTHER / SISTER AGES____

WHO IS LEGALLY RESPONSIBLE FOR THE PATIENT?______________________________ SS#______________

WHAT IS PREFERRED TELEPHONE NUMBER? HOME __________ WORK __________ CELL______________

May we use your cell number to text confirmation of appointments? ______________

SIGNATURE:____ DATE____________________