VICTORIA LYNSKEY
Orthodontist

1. About Your Child

Child's name: _____

Nickname: _____

Birthdate: _____ Age: ____ ☐ M ☐ F ☐ Other

Preferred pronouns: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

2. Accompanying Your Child Today

Name: _____ Relation: _____

Whom may we thank for referring you? _____

General dentist: _____

Last visit date? _____

Siblings? _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Parent's marital status: ☐ Single ☐ Partnered
☐ Married ☐ Divorced ☐ Widowed ☐ Separated

3. Dental Insurance Information

Insurance company name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Adult Coverage? ☐ Yes ☐ No

Subscriber: _____ SSN: _____

Subscriber Birthdate: _____ Group #: _____

4. Responsible Party #1

Name: _____

Address: _____

Phone #: _____

Employer: _____

Occupation: _____

Wk #: _____ Cell #: _____

Relationship to patient: _____

Responsible for account? ☐ Y ☐ N

Appointments? ☐ Y ☐ N

4. Responsible Party #2

Name: _____

Address: _____

Phone #: _____

Employer: _____

Occupation: _____

Wk #: _____ Cell #: _____

Relationship to patient: _____

Responsible for account? ☐ Y ☐ N

Appointments? ☐ Y ☐ N

Child Registration

95 Montgomery Drive, Suite 220 • Santa Rosa, CA 95404 • P: 707.525.1180 • F: 707.525.1554 • **stunningsmile.com**

6. Medical History

Your child's current medical health is: ☐ Good ☐ Fair ☐ Poor

Physician's Name: _____

Phone: _____

Is your child under current care? ☐ Y ☐ N

Is your child taking any prescription or over-the-counter drugs? ☐ Y ☐ N

Please list each one: _____

_____

Has your child reached puberty? ☐ Y ☐ N
Has your daughter begun to menstruate? ☐ Y ☐ N
Is your daughter pregnant? ☐ Y ☐ N
If so, how many months along? _____

Has your child ever had any of the following diseases or medical problems?

☐ Y ☐ N Anemia
☐ Y ☐ N Artificial Bones / Joints / Valves
☐ Y ☐ N Arthritis
☐ Y ☐ N Allergies
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer / Chemotherapy
☐ Y ☐ N Congenital Heart Defect / Heart Murmur
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing / Asthma / Hayfever / Sinus
☐ Y ☐ N Epilepsy / Seizures / Fainting Spells
☐ Y ☐ N Fever Blisters / Herpes
☐ Y ☐ N Stroke or Heart Surgery
☐ Y ☐ N Hemophilia / Abnormal Bleeding
☐ Y ☐ N Hepatitis / Jaundice / Liver Problems
☐ Y ☐ N High / Low Blood Pressure
☐ Y ☐ N Immunocompromised
☐ Y ☐ N Hospitalized for any reason?
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Mitral Valve Problems
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Rheumatic / Scarlet Fever
☐ Y ☐ N Sever / Frequent Headaches
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Tonsils or Adenoids Removed (Age: _____)
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcers / Colitis
☐ Y ☐ N Venereal Disease
☐ Y ☐ N Sensory Processing Issues Type: _____

Please list any serious medical condition(s) your child's had:

_____

Is your child allergic to the following?

☐ Y ☐ N Aspirin
☐ Y ☐ N Metal / Plastics
☐ Y ☐ N Codeine
☐ Y ☐ N Anesthetics
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Tetracycline

7. Dental History

What are the main concerns that you would like to address?

_____

_____

_____

☐ Y ☐ N Has your child been evaluated for or had orthodontics?
☐ Y ☐ N Have there been any injuries to your child's face, mouth or chin?
☐ Y ☐ N Has your child been informed of any missing or extra permanent teeth?
☐ Y ☐ N Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)?
☐ Y ☐ N Does your child floss his/her teeth daily?
☐ Y ☐ N How many times per day does your child brush?
☐ Y ☐ N Does your child have any of the following concerns?
☐ Y ☐ N Thumb/Finger Sucking
☐ Y ☐ N Lip Sucking/Biting
☐ Y ☐ N Clenching/Grinding Teeth
☐ Y ☐ N Nursing Bottle Habits
☐ Y ☐ N Mouth Breather
☐ Y ☐ N Speech Problems
☐ Y ☐ N Nail Biting
☐ Y ☐ N Tongue Thrust
☐ Y ☐ N Snoring at night
☐ Y ☐ N Sleep walking, nightmares, night terrors
☐ Y ☐ N Sleep talking, night sweats
☐ Y ☐ N Tiredness during the day or hyperactivity
☐ Y ☐ N Restless Sleep
☐ Y ☐ N Family history of sleep apnea

Who? _____

8. Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

My records may be used for teaching or research ☐ Y ☐ N

_____
Parent/Guardian Signature Date

_____
Lynskey Othodontics Staff Signature Date

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