We look forward to seeing you:
_______________ at ________am / pm
We would appreciate you arriving 10 minutes before the appt time with this form completed.

Jeffery C. Summers, DMD

Today's Date: ____________________

CHILD FORM

Please take this time to tell us about your child.

Name: ______________________________________
First Middle Last

Child prefers being called ____________ ❑Male ❑Female
Nickname

Child's Birth Date: ______/______/______ Age: __________

Home Address: ______________________________

City: ______________ State: ________ Zip: __________

Home Phone:(______) ______________

Family E-Mail Address: ______________________

School: ______________________ Grade: __________

Hobbies/Sports: ____________________________

Musical Instruments: ________________________

WHO'S ACCOMPANYING THE CHILD TODAY?

Name: ______________________ Relation: ____________

Do you have legal custody of the child? ❑ Yes ❑ No

Are there any other family members being seen by Dr. Summers at this time?

What are their names: ______________________

Please give names and ages of any other children in the family:

____

____

Parental Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

MOTHER'S INFO: ❑Mother ❑Step-Mother ❑Guardian

Name: ______________________ Birth Date: ____/____/____

Address (if different from child's): ______________________

City: ______________ State: ________ Zip: __________

Work:(_____) ______________ Cell:(_____) ______________

Drivers License Number: ______________________

Employer: ______________________________

Address: ______________________________

Occupation: ______________ SS# ______________

FATHER'S INFO: ❑Father ❑Step-Father ❑Guardian

Name: ______________________ Birth Date: ____/____/____

Address (if different from child's): ______________________

City: ______________ State: ________ Zip: __________

Work:(_____) ______________ Cell:(_____) ______________

Drivers License Number: ______________________

Employer: ______________________________

Address: ______________________________

Occupation: ______________ SS# ______________

How did you hear about our office? ______________________

Who may we thank for referring you to our office?

INSURANCE

Primary Dental Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Employer: ______________________________

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____

Insurance Co. Phone:(________) ______________________

Insured Name: ______________________________

Relation to Patient: ______________ Birth Date: _____/_____/_____

SS#: ______________________ Group #: ______________

Secondary Dental Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Employer: ______________________________

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____

Insurance Co. Phone:(__________) ______________________

Insured Name: ______________________________

Relation to Patient: ______________ Birth Date: ______/______/___

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________ Relationship ______________

Billing Address: ______________________________

City: ______________ State: ________ Zip: __________

Home:(______) ______________ Cell:(______) ______________

E-mail Address: ______________________________

Emergency Contact: ______________________________

Relation: ______________ **Home:(_____)** ______________

GENERAL DENTIST

Name: ______________________

Last Dental Exam: ______________________

My dentist referred me to:
❑ You ❑ Another Orthodontist ❑ None

Continued on other side . . .

Eastside Professional Court
4501 Old Spartanburg Road, #2
Taylors, SC 29687

phone (864) 244-7545
fax (864) 244-7767
www.summersortho.com

MEDICAL HISTORY

A complete history is vital for a proper orthodontic evaluation.

Child's Physician: ________________________________

Phone No: ____________________ Date of last visit: ____________

Is he/she taking any prescription medication: ❑ Yes ❑ No

If yes, please list which one(s): ______________________________

____

GIRLS:
Has puberty begun? ❑ **Yes** ❑ **No**
Has menstruation begun? ❑ **Yes** ❑ **No**
Is she pregnant? ❑ **Yes** ❑ **No**
Is she taking birth control pills? ❑ **Yes** ❑ **No**

Has he/she ever had any of the following diseases or medical problems? (Please circle all that apply.)

Abnormal Bleeding	Heart Trouble / Murmur
ADD / ADHD	Hepatitis
AIDS or HIV positive	Immune System
Artificial Bones / Joints	Jaundice or Liver Problems
Asthma	Kidney Problems
Birth Defects	Mental Health / Behavioral
Blood Pressure-High or Low	Mitral Valve Prolapse
Bone Fractures	Neurological Problems
Cancer or Tumors	Nose or Throat
Chest Pain	Pneumonia
Congenital Heart Defect	Polio, Mono or Tuberculosis
Convulsions	Prosthetics
Diabetes	Rheumatic or Scarlet Fever
Ear, Nose or Throat	Rheumatoid / Arthritic
Endocrine or Thyroid	Sickle Cell Disease / Traits
Epilepsy	Skin Disorders
Excessive Weight Loss/Gain	Speech Difficulties
Fainting Spells, Seizures	Stomach Ulcers/Hyperacidity
Handicap / Disabilities	Swelling Ankles
Hay Fever or Sinus Trouble	Vision Difficulties
Hearing Impairment	

Are your child's immunizations current? ❑ Yes ❑ No

Any Hospital Stays / Operations? ______________________________

____

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________________

____

MEDICAL ALERT INFORMATION

Does he / she normally require antibiotic pre-medication prior to dental procedures? ❑ **Yes** ❑ **No** ____________________

Is he / she allergic to any of the following?

Latex	❑ Yes ❑ No	Plastic	❑ Yes ❑ No
Nickel	❑ Yes ❑ No	Aspirin	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Codeine	❑ Yes ❑ No

List any other allergies: ______________________________

DENTAL HISTORY

Has your child ever been evaluated by an Orthodontist? ❑ Yes ❑ No
If so, by whom? ______________________________

Has your child ever had orthodontic treatment? ❑ Yes ❑ No
If so, by whom? ______________________________
Were you happy with the results? ❑ Yes ❑ No

Have other members of the family had orthodontic treatment?
❑ Yes ❑ No Were you happy with the results? ❑ Yes ❑ No
By whom (if other than Dr. Summers)? ____________________

What are your main concerns that you would like orthodontics to correct?

____

Does your child experience any pain, clicking or discomfort in or near the ears? ❑ Yes ❑ No

Has your child ever had any pain or tenderness in his or her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

Have you been informed of missing or extra permanent teeth? ❑ Yes ❑ No

Are you aware of any gum problems? ❑ Yes ❑ No

Have their tonsils or adenoids been removed? ❑ Yes ❑ No

Does/did your child have any of the follow habits? (Please circle)

Clenching / Grinding Teeth	Lip Sucking / Biting
Mouth Breather	Nail Biting

Pacifier User (Until: ____________ age)

Thumb / Finger Sucker (Until: ____________ age)

Will the patient comply with wearing their braces or orthodontic appliances? ❑ **Yes** ❑ **No**

I hereby certify that I have reviewed the above medical and dental history and agree that it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

______________________________ ____________
Parent / Guardian Signature Date

______________________________ ____________
Doctor's Signature Date

smiles for a lifetime