



Columbus Orthodontic Center

CENTER FOR COSMETIC ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD

New Patient Information (Child)

Patient's Name: _____

Today's Date: ____/____/____

Child's Information

Date of Birth: ____/____/____ Age: _____

Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Your relation to child: _____

Responsible Party Information

Mother's Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

Fathers Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Home phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

Other Information

How did you hear about us? (Please circle your answer)

Dentist referral Insurance referral Internet search

Mailer Drive-by

Friends/Family (specify who): _____

Other: _____

What is the Primary reason that your child is seeing an Orthodontist today? _____

Has your child had Phase I orthodontic treatment previously?

Yes No

Has your child seen an orthodontist previously? Yes No

Is your child transferring from another Orthodontist?

Yes No Previous Orthodontist Name _____

Were you satisfied with previous orthodontic treatment of your child? Yes No NA

If No, please explain: _____

What type/types of treatment options are you interested regarding your child?

Traditional Braces

Invisalign clear trays

Clear braces

Lingual/ Hidden braces

For patients that participate in sports, we may recommend **Invisalign** to reduce the chance of sports related injuries.

Does your Child have any hobbies or participate in any sports? _____

Insurance Information

Does your child have insurance? Yes NO

Primary Insurance

Members Name _____

Member ID# (SS#): _____

Date of Birth: ____/____/____

Relationship to Patient: Self Spouse Other

Other (please explain): _____

Insurance Carrier: _____

Insurance Phone #: _____

Insurance address: _____

City: _____ State _____ Zip _____

Group, Plan or Policy #: _____

Employer: _____

Secondary Insurance must be filed by the patient.

Patient Dental History

Dentist Name: _____

Address: _____

Phone: _____

Approximate date of last visit: Month_____/Year_____

Were there any cavities or dental problems present?

Yes No If yes, Please explain: _____

Has your child ever experienced any dental or facial trauma?
(Examples include: Dental injuries, car accident, jaw or facial
injuries related to sports or falling). Yes No

If yes, Please Explain: _____

How often does your child brush his/her teeth? __times a day

Does your child use a Waterpik water flosser? Yes No

Does your child have or have had any of the following habits:

- Thumb sucking Mouth breathing
- Tongue thrusting Nail biting/chewing
- Smoking Snoring

Does your child have or ever had a history of the following?

- Grinding/clenching Jaw popping
- Jaw/Joint clicking Ringing in ears
- Jaw/Joint soreness Excessive headaches

Patient Medical History

Does your child have a hyperactive gag reflex? Yes No

Has your child ever been advised to take antibiotics before
dental treatment? Yes No

For Female Patients only:

Is there a possibility that your child may be pregnant?

Yes No

Has your child started menstrual cycle? Yes No

Does your child have or have had a history of the following:

Please circle "Y" for yes or "N" for no.

Heart murmur	Y	N	Hepatitis	Y	N
Blood disease	Y	N	Herpes	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
HIV/AIDS	Y	N	Adenoids Removal	Y	N
Diabetes	Y	N	Endocrine problem	Y	N
Tonsillitis	Y	N	Prolonged bleeding	Y	N
Jaundice	Y	N	Bone disorder	Y	N
Asthma	Y	N	Rheumatic fever	Y	N
Mouth breathing	Y	N	Sinus Infections	Y	N
Chemotherapy	Y	N	Allergic reaction	Y	N
Surgeries	Y	N	Radiation	Y	N
Cancer	Y	N	Autism/Asperger	Y	N
Mental disorders	Y	N	Anxiety	Y	N
ADD/ADHD	Y	N	Learning Disabilities	Y	N

Please Explain: _____

Please list ALL medical conditions not list above: _____

Is your child currently taking **any** medications? Yes No

If Yes, Please list:

Is your child allergic to **any** medications, food or latex?

Yes No Please list: _____

Is your child under the care of a physician Yes No

Name of Physician: _____

Address: _____

Phone #: _____

X

Patient /Responsible party's Signature: _____

DATE: _____

Doctor's Comments: _____

Doctor's Signature: _____

Date: ____/____/____