Staff Use: Child/Dependent Form

James M. Holland, D.M.D.

Thank you for your interest in our office! Please complete both sides of this form while you wait to be seated.

Patient Name:____
DOB: ________________ Age: _______ M/F Nickname: ____________________
Siblings Names/Ages: ____
Hobbies/Interests: ____
Dentist: ____________________ How did you hear about us?____________________

Responsible Parties

Primary Responsible Party: Please list the person(s) responsible for this account. For divorced/separated parents, please list both parties information - our office requires consent from both parties to treat patients.

Name: ____________________________________ DOB: __________________ M/F
Relationship to Patient:____
Marital Status: ____________________ Spouses Name: ________________________
Address: ____
Street City State Zip Code
Home Phone: _______________________ Cell Phone: __________________________
Email Address: ____

Secondary Responsible Party: (If applicable)
Name: ____________________________________ DOB: __________________ M/F
Relationship to Patient:____
Marital Status: _________________ Spouses Name: ____________________________
Address:____
Street City State Zip Code
Home Phone: _______________________ Cell Phone: __________________________
Email Address: ____

Insurance

Name of Dental Insurance Company: ____
ID#: _____________________________________ Group # ______________________
Name of Insured Employee: ____________________________ DOB: ______________
Employer: _______________________ Occupation: _____________________________

Secondary Insurance: (If applicable)
Name of Dental Insurance Company: ____
ID#: _____________________________________ Group # ______________________
Name of Insured Employee: ____________________________ DOB: ______________
Employer: _______________________ Occupation: _____________________________

James M. Holland, D.M.D.

Habits

___ Thumbsucking ___ Tooth Grinding ___ Fingersucking

___ Tongue Thrusting ___ Lip Biting ___ Nail Biting

___ Speech Irregularities ___ Mouth Breathing ___ Other

Health History

Please list all (if any) allergies: ____
Please list all (if any) medications taken: ____________________________________
Is a physician presently treating patient? If so, please explain: ____________________

____
Have tonsils or Adenoids been removed? _______________________________________
Any difficulty breathing through the nose? _____________________________________
Problems swallowing or chewing food? ____
Any pain when opening or closing mouth? ______________________________________
Jaw clicking or locking? ____

Please check all that apply:

___ Rheumatic Fever ___ Chickenpox ___ Repeated Headaches ___ Asthma
___ Blood Disease ___ Convulsions ___ Measles ___ Food Allergies
___ Repeated Sore Throats ___ Diabetes ___ Mumps ___ Polio
___ Repeated Colds ___ Drug Allergies ___ Tuberculosis ___ Pneumonia
___ Hemophilia ___ Anemia ___ Hay Fever ___ Hepatitis

Any major falls, accidents, or operations? _____________________________________
Any other medical information we should know about? ___________________________

____

What in particular brings you in for an orthodontic evaluation? (Any main concerns?)

____
Would you like your child to have braces if recommended? ______________________

Questionnaire completed by: ___________________________ Date: _______________