Warford Orthodontics

Changing the World, One Smile at a Time.

John H. Warford, Jr., DDS
John H. Warford, Sr., DDS
www.warfordorthodontics.com

Date: _____

About Your Child

Child's Name: _____
LAST FIRST M.I.

Birthday: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

May we contact you by e-mail? Yes _____ No _____

Parent's e-mail address: _____

Dentist Name: _____

Physician Name: _____

School Name: _____

School Name: _____ Grade: _____

Musical Instruments Played: _____

_____

Sports Played: _____

Child's e-mail address: _____

Your Child's Family Information

Father's Name: _____
LAST FIRST M.I.

Address: _____

City: _____ State: _____ Zip: _____

How long at current address? _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Birthday: _____ Age: _____ Marital Status: _____

S.S.#: _____

Have you had orthodontic treatment? _____

Employer: _____

Position: _____

Address: _____

City: _____ State: _____ Zip: _____

How long at current job?

If less than 6 months list previous employer: _____

_____

Mother's Name: _____
LAST FIRST M.I.

Address: _____

City: _____ State: _____ Zip: _____

How long at current address? _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Birthday: _____ Age: _____ Marital Status: _____

S.S.#: _____

Have you had orthodontic treatment? _____

Employer: _____

Position: _____

Address: _____

City: _____ State: _____ Zip: _____

How long at current job?

If less than 6 months, list previous employer: _____

_____

Child's Siblings

Name	Age	Birthdate

Continued on back side

Insurance Information

Primary Dental Insurance

Orthodontic Coverage? Yes _____ No _____
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Group #: _____
Relationship to child: _____

Secondary Dental Insurance

Orthodontic Coverage? Yes _____ No _____
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Group #: _____
Relationship to child: _____

Child's Medical Information

Y N Do you consider your child to be in good health?
Y N Heart Problems?
- **Y N** Rheumatic Fever
- **Y N** Heart Murmur
- **Y N** Shortness of Breath

Y N Liver Problem?
- **Y N** Does your child have hepatitis?

Y N Nerve/Neurological problems?
Y N History of Fainting or Dizziness?
Y N Lung/Breathing Problems?
- **Y N** Asthma

Y N Blood/Bleeding Problems?
Y N History of Tobacco Use?
If so, what kind? _____
Y N Problems with Healing?
Y N Psychological/Emotional Problems?
Y N High/Low Blood Pressure?
Y N Cancer or History of Cancer?
Y N HIV/Aids?
Y N Rheumatism or Arthritis?
Y N History of Drug Use?
Y N Tuberculosis?
Y N Hormone/Endocrine Problems?
Y N Does your child get frequent cold sores?
Y N Does your child have artificial joint/ implants?
Y N Thyroid Problems?
Y N Kidney Problems?

Last physical examination was on: _____
Please list all medications: _____
_____
Y N Is your child currently under medical care?
Y N Are you aware of any disease, condition or problem not listed that we should know about?
If yes, what? _____
Y N Is your child allergic to any medications?
Please list: _____
Y N Does your child have asthma or seasonal/environmental allergies?

Child's Dental Information

Y N Has your child seen a general dentist in the last year?
Y N Any pain, clicking or discomfort in or near the ear (TMJ)?
Y N Has the mouth, face or teeth been injured by a fall or accident?
Y N Have you been informed of missing or extra permanent teeth?
Y N Are you aware of any "gum" or periodontal problems?
Y N Has a physician or dentist advised antibiotics before a dental exam?

Does your child have or ever had any of the following habits?

Y N Cheek, tongue or lip biting
Y N Thumb or finger sucking
Y N Mouth breathing
Y N Speech problems
Y N Clenching teeth
Y N Tongue thrusting
Y N Grind teeth

Y N Did your child ever wear a helmet for head molding?
Y N Has your child been examined by an orthodontist before?
If yes, by whom?
Y N Has your child had a recommendation that they need orthodontic treatment?
Y N Have other members of your family had orthodontic treatment?
If yes, who were they?

The greatest compliment we can receive is the referral of friends and family. Whom may we thank for referring you? _____
_____
Address (if known) _____

Please share your orthodontic concerns: _____
_____
_____

Please share the desired outcome of orthodontic transformation: _____
_____
_____

Please share any special concerns that we can help with: _____
_____
_____

_____ _____
Parent/Guardian Signature **Date**