Date: ________________

Welcome to Morrone, Kaye and Yucha Orthodontics

Initial Child New Patient Questionnaire

The purpose of obtaining this information is to develop a comprehensive baseline plan just for your child! In an effort to provide the best service possible, we ask you to fill this form out in order to help the doctor evaluate and treat your child in the best clinical manner.

Phone Number: __________________________E-Mail:____

Patient Name: ___________________________DOB: ______________ Age:____ Current Grade: ____

Dentist: _________________________________

1. **How did you hear about us?**
   ____ Your Dentist
   ____ **Current MKY Patient; Name _____________________________**
   ____ Family Member
   ____ Online Research Google Search, Website, Facebook, etc.
   ____ Neighborhood Reputation – Word on the Street, Soccer Field, etc.
   ____ Community event we sponsored

2. **What type of treatment options would you like discussed at today's visit?**
   ____ Traditional Metal Braces
   ____ Invisalign for Teens
   ____ Clear Braces
   ____ Retainers (to hold current position/limited tooth movement)
   ____ Other-please explain ____

3. **What is your main concern with your child's smile/bite?** ____

4. **Has your child previously seen an Orthodontist?**

   ____ Yes, if so, was any treatment performed? ____________________________

   ____ No

Siblings in current household, if any:

			Current Patient
Sibling (Circle) Brother / Sister	Name _______________________	D.O.B. __________	Y / N
Sibling (Circle) Brother / Sister	Name _______________________	D.O.B. __________	Y / N
Sibling (Circle) Brother / Sister	Name _______________________	D.O.B. __________	Y / N
Sibling (Circle) Brother / Sister	Name _______________________	D.O.B. __________	Y / N

MEDICAL HISTORY

Please check if your child has or had any of the following:

( ) Allergy to Medication(s)

( ) Allergy to Plastic/Latex/Metal/Other

( ) Tonsils/Adenoids Removed

( ) Frequent Headaches

( ) Facial Injuries – Mouth, Chin

( ) Hepatitis A, B, or C

( ) HIV

( ) Tongue Thrust, Thumb Sucking

( ) Asthma

( ) ADD/ADHD/Learning Disability

( ) Emotional Issues/Anxiety

( ) Frequent Colds

Females only: ( ) onset of menses; Age? _______________

Males only: ( ) onset of puberty: Age? ________________

Please explain any above checked answers: ____

____

Please state any other significant medical history: ____

____

Please list any medications currently being taken:____

____

Is antibiotic premedication needed for dental visits: Yes ____ No ____ Unsure _____

If Yes or Unsure, please explain: ____

Physician's Name: ____

The above information is true to my knowledge. I, as custodial parent/guardian of the above minor child, give my consent for examination of my child by the doctors and staff of Morrone, Kaye and Yucha Orthodontics, P.A.

_____________________________ _____________________________ _____________________

Parent/Guardian Signature Print Name Date

Relationship to Patient____