Charles A. Sadler, Jr., D.D.S., M.S.D.

PATIENT INFORMATION

Date _______________

PLEASE TELL US ABOUT YOUR CHILD

Child's Name: ____
LAST FIRST MI

My child prefers to be called:___________________________

☐Male ☐Female

Date of Birth: ______/______/______ Age: ______________

Child's Home #: (________) __________________________

Child's Home Address: _______________________________

____
CITY STATE ZIP

CHILD'S DENTIST

Name: __________________________ Last visit: _________

____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

____

____

Other siblings & ages: ________________________________

____

Child's School:____________________ Grade: ___________

Hobbies/Sports:___________________________________

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: ____ Marital Status:___________________________

Address: ____ ☐ OWN ☐ RENT
STREET CITY STATE ZIP

How long at this address: ____________ Previous address (if less than 3 yrs.): ___________________________
STREET CITY STATE ZIP

Previous address (if less than 3 yrs.): ____
STREET CITY STATE ZIP

SS #: _______________________________ Birthdate: ________________________ Relationship to Patient: _______________

Employer: __________________________________ Occupation: __________________________No. Years Employed: ______

Spouse's Name: ____Relationship to Patient:___________________________

Employer: __________________________________ Occupation: __________________________No. Years Employed: ______

SS #: _______________________________ Birthdate: __________________________Work #: (________) _______________

Child's Parents/Legal Guardian's Name: ____

Preferred Contacts: Email:____

Home #: (_____________)________________________________ Work #: (_____________)_________________________________

Cell #: (_____________)______________________________ Cell Service Provider: ___________________________________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐Yes ☐No

Insurance Name:______________________________________

Insurance Address: ____________________________________

____
CITY STATE ZIP

Insurance Phone #: (________) _______________________

Group # (plan or policy #):____________________________

Insured's Name: ______________________________________

Relationship to patient: ________________________________

Insured's Birthday:____________________________________

Insured's Employer:____________________________________

Insured's SS #: _______________________________________

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐Yes ☐No ______________

Insurance Name:______________________________________

Insurance Address:____________________________________

____
CITY STATE ZIP

Insurance Phone #: (________) _______________________

Group # (plan or policy #): ___________________________

Insured's Name: ______________________________________

Relationship to patient: ________________________________

Insured's Birthday: ___________________________________

Insured's Employer: ___________________________________

Insured's SS #: _______________________________________

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DENTAL HISTORY

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

____

____

	YES	NO
Has your child ever been evaluated by an Orthodontist or had Orthodontic treatment?	☐	☐
Has there ever been any severe injuries to the face, mouth, teeth, or chin?	☐	☐
List any musical instruments played:_______________		
Have tonsils/adenoids been removed?	☐	☐
Has your child ever been informed of any missing or extra permanent teeth?	☐	☐
Has your child ever had any pain or tenderness in his/her jaw joint (TMJ or TMD)?	☐	☐
Child's General Physician: _______________		
Phone #: (________)_______________ Last Seen _______________		
Is your child currently under the care of a physician for any reason?	☐	☐
Explain: _______________		
Doctor's Name: _______________		
Has puberty begun?	☐	☐
Has menstruation begun? (girls)	☐	☐

Please describe your child's current general health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _______________

Please list all drugs to which your child is allergic: _______________

MEDICAL HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	☐	☐	Ulcers	☐	☐	Convulsions/Epilepsy	☐	☐
Heart Murmur	☐	☐	Fainting/Dizzy Spells	☐	☐	Handicaps/Disabilities	☐	☐
Heart Problems	☐	☐	Hepatitis	☐	☐	Allergies to latex/plastic	☐	☐
Diabetes	☐	☐	HIV/AIDS	☐	☐	Hearing Disorders	☐	☐
Bone Disorders	☐	☐	Mental Health Disorders	☐	☐	Sinus Trouble	☐	☐
Blood Disorders	☐	☐	Herpes (any type)	☐	☐	Asthma	☐	☐
Cancer	☐	☐	Endocrine Disorders	☐	☐	Any Operations	☐	☐
Tuberculosis	☐	☐	Nervous Disorders	☐	☐	☐ Hospital ☐ In-patient		

Please discuss any medical problems that your child has had: _______________

____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

	YES	NO		YES	NO		YES	NO
Thumb/Finger Sucking	☐	☐	Mouth Breather	☐	☐	Nail Biting	☐	☐
Lip Sucking/Biting	☐	☐	Speech Problems	☐	☐	Tongue Thrust	☐	☐
Clenching/Grinding Teeth	☐	☐						

I understand that the information I have given above is correct to the best of my knowledge, that where appropriate credit bureau reports will be obtained, and that it will be held in strict confidence. It is my responsibility to inform Dr. Sadler of any changes in my child's medical and dental status. I hereby authorize release of information for any proposed treatment to my/our insurance company and for insurance payment of said treatment to be paid directly to Sadler Orthodontics. I further authorize release of orthodontic records to other healthcare providers involved in my dental/orthodontic care and the use of these records by Dr. Sadler for teaching purpose and or scientific publication. In addition, I acknowledge that I have received a notice of privacy practices from Sadler Orthodontics.

_______________________________ _______________________________

Signature of Parent or Guardian Date | Signature of Insured Person Date