Jessica Chung-Levy, D.D.S.
Specialist in Orthodontics &
Dentofacial Orthopedics

Tell Us About Your Child

Today's Date ______________________________

Child's Name: ____ Male___ Female___
First M.I. Last

Nickname: ______________________ Birthdate: _______/_______/_________ Age: ___________

School: ______________________ Grade: _____ Hobbies/Sports: ____________________________

Home Address: ____
street town state zip code

Home#: (   ) __________-________________ E-mail: ____________________________________

General Dentist: ____________________________________ Phone#: (   ) _______-_________

Address: ____ Last Visit Date: _____/_____/_____

Parent's Information

Name: ____ E-mail: __________________________

Home#: (   ) _______-__________ Mobile#: (   ) _______-__________ Work#: (   ) _______-__________

Employer: ______________________________ Job Title: _____________________________________

2nd Parent's Information

Name: ____ E-mail: __________________________

Home#: (   ) _______-__________ Mobile#: (   ) _______-__________ Work#: (   ) _______-__________

Employer: ______________________________ Job Title: _____________________________________

Person Responsible for Appointments: Name: ____ .

Best phone # and best times to reach named person? ____.

Person Responsible for Account: _____________________________ Relation: ___________________

SS#: _________-__________-_________(Enter only if you would like us to submit an insurance claim for you)

Please provide dental insurance information if you would like us to file a dental claim on your behalf.

Primary Dental Ins. Co.: _______________ Member's name & date of birth: _________________________Group #: __________

Secondary Dental Ins. Co.: _____________ Member's name & date of birth: _______________________Group #: __________

Whom may we thank for referring you? ____

Other family members/friends seen by us: ____

CONTINUED ON THE BACK

What are the main issues that you would like orthodontic treatment to correct? (Improve alignment, crowding, spacing, overbite, bad bite, or suggested by dentist) ____

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Has your child ever been evaluated or had orthodontic treatment before? Yes__ No__
Have there been any injuries to the face, mouth, teeth or chin? Yes__ No__
List any musical instruments played: ____
Have adenoids or tonsils been removed? Yes__ No__
Has your child been informed of any missing or extra permanent teeth? Yes__ No__
Has your child ever had any pain/tenderness in his/her jaw joint? Yes__ No__
Does your child brush his/her teeth daily? Yes__ No__
Child's Physician:___________________________ Phone#: ( )_______-_________ Date of Last Visit:_________________
Is your child currently under the care of a physician? Yes__ No__
Has patient reached puberty? Females: has menstruation begun? Yes__ No__ Males: has voice started changing? Yes__ No__

Please describe your child's current physical health: **Good__** **Fair__** **Poor__**
Please list all drugs that your child is currently taking: ____
Please list all drugs/things that your child is allergic to: ____

Has your child ever had any of the following medical problems?

Abnormal Bleeding	Yes___	No___	Diabetes	Yes___	No___
Allergies to Any Drugs	Yes___	No___	Handicaps/Disabilities	Yes___	No___
Allergic to Latex/Metals	Yes___	No___	Hearing Impairment	Yes___	No___
Allergic to Plastic	Yes___	No___	Hemophilia	Yes___	No___
Any Hospital Stays	Yes___	No___	Hepatitis	Yes___	No___
Any Operations	Yes___	No___	HIV+/AIDS	Yes___	No___
Asthma	Yes___	No___	Migraines	Yes___	No___
Cancer	Yes___	No___	Rheumatic/Scarlet Fever	Yes___	No___
Congenital Heart Defect/Murmur	Yes___	No___	Tuberculosis (TB)	Yes___	No___
Convulsions/Epilepsy	Yes___	No___	History of Cleft Palate/Lip	Yes___	No___

Does your child have any of the following habits?

Clenching/Grinding Teeth	Yes___	No___	Prolonged use of Nursing Bottle	Yes___	No___
Lip Sucking/Biting	Yes___	No___	Speech Problems	Yes___	No___
Mouth Breather	Yes___	No___	Thumb/Finger Sucking	Yes___	No___
Nail Biting	Yes___	No___	Tongue Thrust	Yes___	No___

Please provide any additional information / comments that you feel would enable us to provide the best experience for you and your child during your visit with us.

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian ____ **Date**________________________

THANK YOU FOR FILLING OUT FORM COMPLETELY