

Mid Peninsula Orthodontics

1 Tell us about your child

Today's Date: _____

Child's Name: _____

Nickname: _____ Sex: _____

Birthdate: _____ Age: _____

Home Address: _____

CITY STATE ZIP
Phone: _____ Email: _____

School: _____ Grade: _____

2 Accompanying your child today

Name: _____ Relation: _____

Do you have legal Custody? Yes No

Whom may we thank for referring you?

General Dentist: _____

Last visit date: _____

Siblings: _____ sex: _____ DOB: _____

_____ sex: _____ DOB: _____

_____ sex: _____ DOB: _____

Parent's Marital status:

Single Widowed Married Divorced Separated

5 Insurance for Dual Coverage

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Adult Coverage? Y / N

Subscriber _____ SSN _____

Subscriber B-day _____ Group # _____

Lifetime Ortho Benefit _____ Deductible? _____

Paid at what % _____ Paid Monthly/Quarterly ?

3 Mother's Information

Step Mother / Guardian

Name: _____

Address: _____

Home #: _____

Employer: _____

Wk#: _____ Cell#: _____

Email: _____

Occupation: _____

SSN: _____ Birthdate _____

Responsible for account? Y/N for appointments? Y/N

4 Father's Information

Step Father / Guardian

Name: _____

Address: _____

Home #: _____

Employer: _____

WK #: _____ Cell #: _____

Email: _____

Occupation: _____

SSN: _____ Birthdate _____

Responsible for account? Y/N for appointments? Y/N

5 Insurance Information

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Adult Coverage? Y / N

Subscriber _____ SSN _____

Subscriber B-day _____ Group # _____

Lifetime Ortho Benefit _____ Deductible? _____

Paid at what % _____ Paid Monthly/Quarterly ?

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6 Medical History

Your child's current medical health is:

Good Fair Poor

Physician's Name: _____

Phone #: _____

Is your child under current care? Yes No Explain: _____

Is your child taking any prescription or over-the-counter drugs? Yes No

Please list each one _____

Has your child reached puberty? Yes No

Has your daughter begun to menstruate? Yes No

Is your daughter pregnant? Yes No
If so how many months along? _____

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

- Y N Anemia/Radiation Treatment
Y N Artificial bones/ Joints / Valves
Y N Arthritis
Y N Allergies _____
Y N Cancer/ Chemotherapy
Y N Congenital Heart Defect/Heart Murmur
Y N Diabetes
Y N Difficulty Breathing / Asthma / Hayfever / Sinus
Y N Epilepsy / Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Stroke or Heart Surgery
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis / Jaundice / Liver Problems
Y N High / Low Blood Pressure
Y N Immunocompromised
Y N Hospitalized for Any Reason? _____
Y N Kidney Problems
Y N Mitral Valve Problems
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Sinus Problems
Y N Tires Easily
Y N Tonsils or Adenoids Removed (Age: _____)
Y N Tuberculosis (TB)
Y N Ulcers / Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that your child may have had:

Is your child allergic to any of the following?

- Y N Aspirin Y N Metal / Plastics
Y N Codeine Y N Anesthetics
Y N Erythromycin Y N Latex
Y N Penicillin Y N Tetracycline
Other: _____

7 Dental History

What are the main concerns that you would like orthodontics to accomplish for your child?

Has your child been previously evaluated or had orthodontics? Y N

Have there been any injuries to your child's face, mouth or chin? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? Y N

How many times per day does your child brush _____

Does your child floss his/her teeth daily? Y N

Does your child have any of the following concerns?

- Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting
Y N Clenching/Grinding Teeth
Y N Nursing Bottle Habits
Y N Mouth Breather
Y N Speech Problems
Y N Nail Biting
Y N Tongue Thrust
Y N Snoring at night
Y N Sleep walking, nightmares, night terrors
Y N Sleep talking, night sweats
Y N Tiredness during the day or hyperactivity
Y N Family history of sleep apnea

8 I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.**

Parent/Guardian's Signature _____

Date _____

Mid Peninsula Staff Signature _____

Date _____

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