Katherine J. Curry, D.M.D.
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ORTHODONTICS &
DENTOFACIAL ORTHOPEDICS

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LET'S GET ACQUAINTED

CHILD

Today's Date____________________

Patient Name____ Birthdate____/____/____ Age__________
Last First Middle Initial

Patient Address____
Street Address City State Zip

Home Phone#(_____)______________________M_____F_____Nickname______________________

Father's Name______________________ ☐ Married ☐ Divorced ☐ Single ☐ Widowed Birthdate____/____/______

Address(if different from above)______________________Home#(____)____________Cell#(____)____________

Employer______________________Work #______________SS #_____-_____-_____E-Mail______________

Mother's Name______________________ ☐ Married ☐ Divorced ☐ Single ☐ Widowed Birthdate____/____/______

Address(if different from above)______________________Home#(____)____________Cell#(____)____________

Employer______________________Work #______________SS #_____-_____-_____E-Mail______________

Financial Responsibility____

Referred By____

Name(s) of any other family member previously treated in our office______________________

DENTAL HISTORY

Current Family Dentist____Phone #(______)______________

Check (✓) if you have had problems with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Food Collection between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity to sweets
☐	☐	Bleeding gums	☐	☐	Grinding Teeth	☐	☐	Sensitivity to cold	☐	☐	Sensitivity when biting
☐	☐	Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to hot	☐	☐	Sores/growth in mouth

How often do you floss?______________________ How often do you brush?______________________

HEALTH HISTORY

Is your child currently under the care of a physician? ☐ Yes ☐ No If yes, explain______________________

Physicians Name______________________________Date of last visit______________________

Has your child had any serious illness or operations?_________If yes, describe______________________

Has a physician ever told you to premedicate your child before any dental treatment? ☐ Yes ☐ No

If yes, please explain____

Check (✓) if your child has or has had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aids/HIV positive	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Skin Rash
☐	☐	Tuberculosis	☐	☐	Epilepsy	☐	☐	Jaw Pain	☐	☐	Stroke
☐	☐	Arthritis, Rheumatism	☐	☐	Fainting	☐	☐	High Blood Pressure	☐	☐	Glaucoma
☐	☐	Artificial Heart Valves	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Heart Problem
☐	☐	Artificial Joints/Replacements	☐	☐	Pace Maker	☐	☐	Rheumatic Fever	☐	☐	Scarlet Fever
☐	☐	Back Problems	☐	☐	Chemical Dependency	☐	☐	Circulatory Problems	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Radiation therapy	☐	☐	Cancer	☐	☐	Hemophilia
☐	☐	Blood Disease	☐	☐	Nervous Problems	☐	☐	Respiratory Disease	☐	☐	Asthma
☐	☐	Kidney Problems	☐	☐	Shortness of Breath	☐	☐	Thyroid Problems	☐	☐	Headaches
☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐	Liver Disease	☐	☐	Anemia
☐	☐	Tobacco Habit									

MEDICATIONS

List medications your child is taking:

1. ______________________
2. ______________________
3. ______________________

ALLERGIES

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Sulfa
☐	☐	Acetaminophen/Tylenol	☐	☐	Latex
☐	☐	Ibuprofen/Advil	☐		______________________

PLEASE COMPLETE BOTH SIDES

PRIMARY DENTAL INSURANCE

Subscriber Name____
Last First Initial

Relationship to Patient________________________Birthdate____/____/____ID #____________

Employer Name________________________Occupation________________________

Insurance Company____

Insurance Address________________________Phone #________________________

Group #____________________Orthodontic Benefits: ☐ Yes ☐ No

Notes:____

Are you covered by additional orthodontic insurance? ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Subscriber Name____
Last First Initial

Relationship to Patient________________________Birthdate____/____/____ID #____________

Employer Name________________________Occupation________________________

Insurance Company____

Insurance Address________________________Phone #________________________

Group #____________________Orthodontic Benefits: ☐ Yes ☐ No

Notes:____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I hereby authorize payment directly to: Katherine J. Curry, D.M.D and/or Jimin Oh, D.M.D. of the group insurance benefits otherwise payable to me.

Date________________Signature________________________________

Date________________Reviewed by________________________________
Katherine J. Curry, D.M.D. and/or Jimin Oh, D.M.D.

FOR OFFICE USE ONLY

1. Class I________ II________ III________
2. Mandibular arch length shortage:________
3. Maxillary anterior teeth: Spaced________
   Protrusive________Deep overbite________
4. Lip Posture Fullness:________
5. Crossbite: Right______ Left______ Anterior______
6. Finger sucking habit:______ Tongue thrust:______
7. Observation: 3mos.______ 6mos.______
8. TMJ: WNL______ or Describe________
9. Oral Cancer Screening: No Visible Lesions________
   Suspected Lesion Location________
10. Soft Tissue Exam: WNL________
11. Rx: Full____ Minor____ Invisalign____
12. Doctor: KJC______ JO______

PAN:______ CEPH:______PHOTOS______