Dr. Geri Hunter Portsmouth Pediatric Dentistry and Orthodontics

Child

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

			Г	Date:	-
Child First, Last Name	Prefers to be called	:			
Mailing Address:	_City:State	: Zip:	Home I	Phone:	
School:		Gr	rade:	Age:	
Hobbies/Sports/Interests:		b-1			
Who is accompanying this child today?	Relationship to Patient:				
Does this person have legal custody of the child? Yes $\ \Box$	No 🗆				
Child's general dentist:	Date of last cleaning	g:	Pending d	ental work?	-
Who may we thank for referring you to our office?		****			
Parents: Married	Divorced □ Separated	i 🗆	Other		
	-		and the state of t		
Mother - Title, First, Last Name:	Home Phone:				
Work Phone:	Cell Phone				
Employer:	Occupat	ion:			-
Address(if different from child):	City:		State:	Zip:	State of the State
Father - Title, First, Last Name:	Home Phone:				
Work Phone:	Cell Phone				
Employer:	Occupat	tion:			Broads and property and a
Address(if different from child):	City:		State:	Zip:	
	Family Facts				
Brothers (with ages):					
Sisters (with ages):					marketersold (
Have any family members received orthodontic treatme	ent? Please Name:			At the state of th	Balling State
Have any relatives been treated in our office?	Please Name:				normalist.
What are your chief orthodontic concerns?		and the second second second			
Has your child ever been evaluated for or previously ha	ad_orthodontic treatment?				

Dental Insurance

Name of Insured:	Insured Social Secur	Insured Social Security #:		
Insured's DOB:	Employer:			
Insurance Company:	Group # :			
	Medical History:			
Child's Physician:	Phy	vsician Phone #:		
Date of last exam:	Is yo	Is your child in good health?		
Does your child have a heart condition wh	ich requires him/her to take antibiotics pric	or to dental treatment? YES \Box NO \Box		
Circle	any of the following medical issues, which	apply to your child:		
Have the tonsils and/or adenoids been rem	nouth, teeth or chin? If yes, describe injury	Clenching/grinding teeth Clicking/popping of jaw Jaw joint pain (TMJ) Locking of jaw Lip sucking/biting Mouth breather Nail biting Snoring Speech problems Thumb sucking habit Tongue thrust until what approximate age?		
Is your child allergic to any drugs, latex, o	r metals? If yes, please specify.			
Please provide additional information on a	any above circled medical issues or any oth	er conditions we should be aware of.		
I understand that the information I hay confidence, and that it is my responsibi information.	e given is correct to the best of my knov lity to inform this office of any changes	wledge, that it will be held in the strictest of in my child's medical/dental status or personal		
Signature		Date		