

# Welcome to our office!

Please take a few minutes to provide us with the following important information.

Today's date: \_\_\_\_\_

**Patient's full name:** \_\_\_\_\_  
 Home address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Sex M F  
 Birth date (DD/MON/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dentist: \_\_\_\_\_ Last visit \_\_\_\_\_  
 School: \_\_\_\_\_  
 Patient's e-mail: \_\_\_\_\_

**Family Information**

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

- Parents are married separated divorced remarried
- Child lives with parents mother father other
- Who should receive routine information about treatment progress? parents mother father other

**Patient's Mother**

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Home address ( ) same \_\_\_\_\_  
 Home phone number ( ) same \_\_\_\_\_  
 City \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 e-mail \_\_\_\_\_

**Patient's Father**

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Home address ( ) same \_\_\_\_\_  
 Home phone number ( ) same \_\_\_\_\_  
 City \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 e-mail \_\_\_\_\_

**Other adults we should know about? NO**

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Relationship to patient? \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (O) \_\_\_\_\_

**Patients siblings? Age School**

Name \_\_\_\_\_  
 Name \_\_\_\_\_  
 Name \_\_\_\_\_

*How did you find us? '1' indicating the top reason for coming to our office and '2' to indicate other ways you heard about our office.*

- 1 2 Referred by dentist
- 1 2 Referred by family/friend
- 1 2 Family member was treated/is being treated by Dr. Dumore
- 1 2 One of our patients recommended you \_\_\_\_\_
- 1 2 Heard about us through school talk, church, community activity
- 1 2 Saw office in area
- 1 2 Magazine/Newspapers
- 1 2 Invisalign referred me
- 1 2 Invisalign web site / customer service
- 1 2 Our website
- 1 2 Our team member
- 1 2 Yellow Pages
- Other \_\_\_\_\_

**Medical Information: Does your child have (or has had) any of the following? Please indicate with an [x]**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies/sensitivities to medicine | <input type="checkbox"/> Eye problems                              | <input type="checkbox"/> Ear aches                       |
| <input type="checkbox"/> Tonsillitis (or date removed) _____ | <input type="checkbox"/> Stomach problems                          | <input type="checkbox"/> Asthma: uses inhaler ____x/week |
| <input type="checkbox"/> Liver problems / hepatitis          | <input type="checkbox"/> Bleeding disorders / transfusion / anemia | <input type="checkbox"/> Kidney problems                 |
| <input type="checkbox"/> Heart problems                      | <input type="checkbox"/> Rheumatic fever                           | <input type="checkbox"/> Thyroid disorder                |
| <input type="checkbox"/> HIV / AIDS                          | <input type="checkbox"/> Emotional/ nervous/ psychiatric issues    | <input type="checkbox"/> Bone disorder                   |

Describe any other medical issues (medication, illness, surgery) if not listed above.

Physician's name \_\_\_\_\_

**Girls:** Has menstruation begun? Date \_\_\_\_\_ **Boys:** Has voice changed? Yes No

Has there been a recent growth spurt? Yes No Date \_\_\_\_\_

