

Please Complete Both Sides and Bring to Your Child's Appointment. Thank You.

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Patient Information

CHILD'S FULL NAME: _____ SEX:(Circle) **M** **F** BIRTHDATE: _____

CHILD LIVES WITH: (Circle) **Both Parents** **Mother** **Father** **Guardian**

Father's Information

Mother's Information

Full Name: _____

Full Name: _____

Home Address: _____

Home Address: _____

City, State Zip: _____

City, State Zip: _____

Home Phone: _____

Home Phone: _____

Cell: _____

Cell: _____

eMail: _____

eMail: _____

Employed By: _____

Employed By: _____

Employer Phone Number: _____

Employer Phone Number: _____

Occupation: _____

Occupation: _____

Social Security #: _____

Social Security #: _____

Date of Birth: _____

Date of Birth: _____

Dental Insurance Co: _____

Dental Insurance Co: _____

Insurance Phone #: _____

Insurance Phone #: _____

Group #: _____

Group #: _____

Subscriber ID/Contract #: _____

Subscriber ID/Contract #: _____

Other Insurance Coverage Information

Insured Party's Name: _____

Relationship to Child: _____

Employer: _____

Insurance Co: _____

Group #: _____

Subscriber ID #: _____

Insurance Phone #: _____

Alternate Number - Emergency

(Friend, neighbor, relative, etc.)

Name: _____ Relationship to Child: _____ Phone: _____

Referral Source

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: _____ Relationship: _____

*Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.*

Please be as complete as possible

Family Physician or Pediatrician: _____

Specialists: _____

Medical History

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS or HIV Positive			Counseling			Kidney Disorder		
Allergies <input type="checkbox"/> LATEX <input type="checkbox"/> MEDICINE			Cystic Fibrosis			Muscular Dystrophy		
Arthritis			Developmental Challenges			Motor Skills Delayed		
Artificial Prosthesis/Joints/Pins			Diabetes			Reflux		
Asperger Syndrome			Down Syndrome			Shunt		
Asthma			Eating Disorder			Speech Delayed		
Attention Deficit Disorder/Hyperactivity			Epilepsy/Seizures			Surgery		
Autism Spectrum Disorder			Hearing Impaired/Deafness			Thyroid Problems		
Blood Disorder/Anemia			Heart Disorder/Surgery			Vision Impaired/Blindness		
Cancer			Hepatitis/Liver Disorder			Other		
Cerebral Palsy			Infectious Disease (MRSA, TB, other)			Other		

Please explain any YES answers _____
or other health problems: _____

- Is your child: 1. Allergic to Penicillin Erythromycin Ceclor Sulfa Tree Nuts Other _____
2. Taking any medicine now? (Circle) YES NO Explain: _____
3. At the appropriate grade level for his/her age? (Circle) YES NO Explain: _____

Is there any other issue we should know to help us better relate to your child? (Circle) YES NO If yes, explain below:

Dental History

Any previous dental experience? (Circle) YES NO Where: _____

What was done: _____ When: _____

Child's reaction: _____ Parent's reaction: _____

Main dental concerns: _____

Has your child ever had injuries to the head or neck? (Circle) YES NO Explain: _____

Does/did your child have any oral habits? (Circle) Thumb Finger Pacifier Other _____

Names and ages of other children in the household: _____

Dietary History

Does your child snack frequently? (Circle) YES NO On what? _____

Does/did your child take a bottle to bed? (Circle) YES NO Explain: _____

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature: _____ Date: _____
(Parent/Guardian)