Darron R. Mortenson, DMD, MS

Child/adolescent form

36283 N. Gantzel Rd. Suite 102 ~ San Tan, AZ 85140 ~ (480) 4571623
3011 S. Lindsay Rd. Suite 108 ~ Gilbert, AZ 85295 ~ (480) 963-8001
9101 E. Brown Rd. Suite 102 ~ Mesa, AZ 85207 ~ (480)565-8500

Referred By_____ Date _____
Patient's Name_____ Preferred Name _____
Birthdate _____ Age_____ Sex_____ School_____ Grade _____
Patient's Dentist_____ Physician _____
Parent 1 Name _____ SSN _____Date of Birth_____
Home Address_____ Hm Phone _____ **Email**_____
City/State/Zip _____ Work Phone _____ Cell _____
Occupation _____ Employed By _____
Parent 2 Name_____ SSN_____Date of Birth_____
Home Address_____ Home Phone _____
City/State/Zip _____ Work Phone _____ Cell _____
Occupation _____ Employed By _____
Primary Dental Insurance _____Phone_____
Insured Name_____Relationship_____
Name of any family members we have seen _____
Names and Ages of Other Children in the family _____
Person(s) responsible for Payment of Account_____
Address and Relationship to Patient _____

MEDICAL HISTORY

Is the patient in good health?_____ Please list any history of major illness or medical conditions (give dates) _
_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	☐	HIV/AIDS	☐	ATTENTION DEFICIT	☐	LIVER INVOLVMENT	☐
MITRAL VALVE PRO	☐	ANEMIA	☐	KIDNEY PROBLEMS	☐	HEPATITIS	☐
HEART MURMUR	☐	EPILEPSY	☐	ENDOCRINE PROBLEMS	☐	BLOOD DISORDERS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	PROLONGED BLEEDING	☐	DIABETES	☐
PNEUMONIA	☐	FAINTING OR DIZZINESS	☐	TUBERCULOSIS	☐	AUTISM_____	☐

Does patient have tendency to: Colds ____ Sore Throats ____ Ear Infections ____ Cold Sores _____
Have tonsils and adenoids been removed? ____ What Age? _____ List any drugs or medications now being taken and reason. _____
LIST ANY ALLERGIES OR DRUG SENSITIVITY _____
Has the patient reached puberty: Girls-has she started menstruation ____ If so date of onset _____
Boys-has his voice changed _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____
Has the patient had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? _____
Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____ Has the patient ever sucked a thumb or fingers? **Y /N** Age _____
Any pain in or near the ears? **Y / N** Does the patient have any speech problems? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N** Has either parent had orthodontic treatment? **Y / N**
List any musical instruments played _____
Interests or hobbies_____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature (parent or guardian's) _____ Reviewed By:_____