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WELCOME to our office ! Please help us serve your needs by completing this information sheet.

Today's Date: _____

Name: _____ Preferred First Name: _____

Date of Birth: _____ Age in years: _____ Male / Female Home Phone: _____

Home Address: _____ City, State, Zip: _____

School : _____ Grade: _____

Interests and Activities: _____

List Brothers/Sisters and ages: _____

Child's Parent's marital status: Single Married Widowed Divorced Separated

Mother's Name: _____ **Father's Name:** _____

SSN: _____ Phone: _____ SSN: _____ Phone: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Employer: _____ Phone: _____ Employer: _____ Phone: _____

Business Address: _____ Business Address: _____

City, State Zip: _____ City, State, Zip: _____

Person(s) (other than parents) responsible for account: _____ SSN: _____

Address: _____ City, State, Zip: _____

Employer: _____ Work Phone: _____ Home Phone: _____

Business Address: _____ City, State, Zip: _____

Is the patient covered by orthodontic insurance? _____ If yes, please provide an insurance card (if available).

Insured's Name: _____ Insurance Company: _____

Insured's Date of Birth: _____ SSN: _____ Group #: _____

Insurance Co's Address: _____ Insurance Co's Phone: _____

Whom may we thank for referring you to our office?

Has your family dentist expressed specific orthodontic concerns?

What is your primary reason for seeing the orthodontist?

Do you have any specific concerns regarding orthodontic treatment?

Is there anything about the appearance of your child's teeth or facial profile that you would like to see changed?

Have you or any other family members been treated by our office? _____ Names: _____

Have you ever been seen or treated by another orthodontist? _____ Orthodontist's Name: _____

City: _____ How long did treatment last? _____

What did the treatment involve? _____

Do you anticipate a move or transfer in the near future?

Who is responsible for making appointments? _____ Work Phone: _____ Home Phone: _____

Medical Information

Physician: _____ City: _____

Date of last physical exam: _____ Height: _____ Weight: _____

Is your child in good health? Yes / No If "No" please explain: _____

Does your child have a history of any major illness?

Has your child had any major operations?

Has your child had general/local anesthesia complications?

Has your child been hospitalized in the last five years?

Does your child have any prosthetic joints/implants?

Does your child require antibiotic pre-medication for dental procedures?

Has puberty begun? Yes / No (Girls) Has menstruation begun? Yes / No
Circle any of the following conditions which are applicable to your child:
Anemia/Radiation Treatment Epilepsy/Seizures/Fainting Spells Immunity Disorders
Asthma/Allergies/Arthritis Fever Blisters/Herpes Kidney Problems
Blood Transfusion Heart Attack/Stroke Mitral Valve Prolapse
Brain Disorder Heart Murmur Psychiatric Problems
Cancer/Chemotherapy Ulcers/Colitis/Stomach Problems Rheumatic/Scarlet Fever
Congenital Heart Disease Heart Surgery/Pacemaker Recent Cold or Flu
Diabetes/Tuberculosis (TB) Hemophilis/Abnormal Bleeding Severe/Frequent Headaches
Difficulty Breathing Hepatitis/Liver Disorder Shingles
Drug/Alcohol Abuse High/Low Blood Pressure Sinus Problems
Emphysema/Glaucoma HIV+/AIDS Venereal Disease
Are there any conditions an orthodontist or oral surgeon should be aware of?

Is your child allergic to any of the following? Dental Anesthesia Aspirin Latex
Penicillin Codeine Tetracycline Any Metal/Plastic Erythromycin
Other: _____

List medications your child is currently taking. Give reasons:

Please use this space for additional comments:

Dental Information

Family Dentist: _____

Date of last check-up: _____ Date of last cleaning: _____ Date of last dental x-rays: _____

Have any primary (baby) teeth been removed by the dentist?

Have any permanent teeth been removed by the dentist?

Were there any complications with tooth extractions?

Has your child ever had any injuries to the face, mouth, teeth, or chin?

Has your child ever lost any teeth due to trauma?

Has your child had any periodontal (gum) problems?

Has your child had trouble with bleeding gums?

Does your child have clicking or pain near the ears?

Does your child have chronic headaches or facial pain?

Has your child had his/her tonsils or adenoids removed? Yes/ No If "Yes", at what age: _____

Has your child ever been treated by a speech pathologist?

Has anyone in the family had jaw surgery to correct a strong or weak chin?

Does your child have any of the following habits?

Thumb/Finger Sucking Mouth Breather Speech Problems Tongue Thrust Nail Biting

Clench/Grind Teeth Nursing Bottle Lip Sucking/Biting Night Snoring

I certify that the above information is correct to the best of my knowledge. I will notify Dr. Edmonds of any changes in my child's medical

status. I authorize Dr. Edmonds office to release pertinent information to my insurance company. I understand that, where appropriate,

credit bureau reports may be obtained.

Parent's Signature: _____ Date: _____