



ROSS W. STRYKER, D.D.S., P.C. Specialist in Orthodontics for Children and Adults

590 Lynn · PO Box 1193 · Lebanon, MO 65536

100 Lafayette Circle · Waynesville, MO 65583

800.417.GRIN (4746) 417.532.9532 FAX 417.532.5805 573.774.5187 FAX 573.774.5805

### Adolescent Patient Information

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: M F  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Hobbies/Interests: \_\_\_\_\_  
 Siblings (names & ages): \_\_\_\_\_  
 Patient's Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Whom may we thank for referring you to us? \_\_\_\_\_  
 Has any member of your family been a patient with us? Yes [ ] No [ ]  
 Names: \_\_\_\_\_  
 Who will be accompanying your child today? \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Parent's Marital Status: Married [ ] Divorced [ ] Widowed [ ] Single [ ] Separated [ ]  
 Child Lives With: Both Parents [ ] Mother [ ] Father [ ] Guardian [ ]

### Responsible Party/Parent Information

<p><b>Father/Guardian</b>          Name: _____          Address: _____          Home Phone: _____          SS#: _____ DOB: _____          Employer: _____          Length of Employment _____          Work Phone: _____ Cell Phone: _____          E-Mail: _____</p> <p><b>Mother/Guardian</b>          Name: _____          Address: _____          Home Phone: _____          SS#: _____ DOB: _____          Employer: _____          Length of Employment _____          Work Phone: _____ Cell Phone: _____          E-Mail: _____</p> <p><b>Primary Orthodontic Insurance</b>          Insurance Co. Name: _____          Employer: _____          Insurance Co. Phone: _____          Group #: _____ ID# _____          Policy Owner's Name: _____          Relationship to Patient: _____</p>	<p><b>Stepfather</b>          Name: _____          Address: _____          Home Phone: _____          SS#: _____ DOB: _____          Employer: _____          Length of Employment _____          Work Phone: _____ Cell Phone: _____          E-Mail: _____</p> <p><b>Stepmother</b>          Name: _____          Address: _____          Home Phone: _____          SS#: _____ DOB: _____          Employer: _____          Length of Employment _____          Work Phone: _____ Cell Phone: _____          E-Mail: _____</p> <p><b>Secondary Orthodontic Insurance</b>          Insurance Co. Name: _____          Employer: _____          Insurance Co. Phone: _____          Group #: _____ ID# _____          Policy Owner's Name: _____          Relationship to Patient: _____</p>
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## Health History

<b>Has your child:</b>	<b>Is your child in good health?</b> Yes [ ] No [ ]
Ever been evaluated or had orthodontic treatment before? Yes [ ] No [ ]	<b>Has your child had any history of:</b>
If yes, by whom? _____	(If applicable, please circle)
Ever had any injuries to the face, mouth, teeth, chin? Yes [ ] No [ ]	Allergies to latex, plastic, or any metals Yes [ ] No [ ]
Had adenoids or tonsils removed? Yes [ ] No [ ]	Asthma, tuberculosis (TB), allergies or hay fever? Yes [ ] No [ ]
Ever been informed of any missing/extra teeth? Yes [ ] No [ ]	Congenital heart defect or heart murmur? Yes [ ] No [ ]
Ever had any pain/tenderness/clicking in jaw joint? Yes [ ] No [ ]	Convulsions, epilepsy, or seizures? Yes [ ] No [ ]
	Diabetes, kidney, or liver problems? Yes [ ] No [ ]
<b>Does/did your child have any of the following habits?</b>	Hemophilia, hepatitis, HIV+/AIDS Yes [ ] No [ ]
Clenching/grinding teeth (at night) Yes [ ] No [ ]	Hospital stays or operations Yes [ ] No [ ]
Mouth breather Yes [ ] No [ ]	Hearing impairment, handicaps, or disabilities? Yes [ ] No [ ]
Nail biting Yes [ ] No [ ]	Rheumatic or scarlet fever? Yes [ ] No [ ]
Speech problems Yes [ ] No [ ]	Has puberty begun? Yes [ ] No [ ]
Tongue thrust Yes [ ] No [ ]	Has menstruation begun? (girls) Yes [ ] No [ ]
Thumb, finger, lip sucking or biting Yes [ ] No [ ]	<b>Does your child smoke or use smokeless tobacco?</b> Yes [ ] No [ ]
Does/did your child brush his/her teeth daily? Yes [ ] No [ ]	
Please discuss any medical problems that your child has/had: _____	
_____	
Please list all drugs your child is currently taking: _____	
Please list all drugs your child is allergic to: _____	

Neighbor or Relative not living with you.
Name: _____ Phone: _____
Address: _____

<p>I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental service my child may need. I acknowledge that I have read and received a copy of the Privacy Consent form as provided by the office of Dr. Ross W. Stryker, D.D.S., P.C.</p> <p>If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductibles that my insurance does not cover.</p>	
_____ Signature of parent or guardian	_____ Date