

## WELCOME

We would like to welcome you to the office of Dr. Kimi S. Caswell.  
Our staff is dedicated to providing excellence in orthodontic care.

### CHILD INFORMATION

**Please tell us a little about yourself**

Your name \_\_\_\_\_ Preferred name \_\_\_\_\_ M/F  
Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Hobbies & interests \_\_\_\_\_  
Do you have any relatives that we've seen in our office before? \_\_\_\_\_  
Names: \_\_\_\_\_  
How do you feel about wearing braces? \_\_\_\_\_  
Do you have any friends that wear braces? \_\_\_\_\_  
What is your primary concern for today's visit? \_\_\_\_\_  
\_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Which office is most convenient for you?    Honolulu    Kahala    Mililani

### FAMILY INFORMATION

FATHER	MOTHER
Name _____	Name _____
Address _____	Address _____
How long at address? _____ Rent/own _____	How long at address? _____ Rent/own _____
Work phone _____	Work phone _____
Cell phone _____	Cell phone _____
Occupation _____	Occupation _____
Date of birth _____	Date of birth _____
Dental Insurance _____	Dental Insurance _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
How long at current job? _____	How long at current job? _____
Are parents:    single    married    divorced    separated	
Do mom, dad and child all live together? Y N    If No, please explain: _____	
Person responsible for account _____	
EMERGENCY contact _____ Phone _____	
Responsible party signature _____ Date _____	

## CHILD'S HEALTH HISTORY

Are you in good health? Y N, If No, please explain \_\_\_\_\_

Name of Physician \_\_\_\_\_

Have you been hospitalized or had operations? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Have you had tonsils and adenoids removed? Y N, if Yes, at what age? \_\_\_\_\_

Are you currently taking any medications? Y N, If Yes, please describe \_\_\_\_\_

Do you most resemble Mom or Dad? Have you begun puberty? Y N, If Yes, at what age? \_\_\_\_\_

Do you have any allergies? Y N, If yes, please explain: \_\_\_\_\_

Do you have frequent colds, sore throat, canker sores? Y N, If Yes, please explain: \_\_\_\_\_

Do you have frequent headaches or muscle soreness around the head and neck? Y N \_\_\_\_\_

If yes, how do you treat the pain? \_\_\_\_\_

Have you been diagnosed or treated for any of the following? (please circle)

Diabetes	Epilepsy	Blood disorders	Pneumonia	HIV+	Drug allergy	Asthma
Tuberculosis	AIDS	High Blood Pressure	Herpes Rheumatic	Fever		Fainting
Heart Trouble	Convulsions	Hepatitis	Venereal Disease	Endocrine problems		Bone Disorders

Please list other medical conditions, or explain above conditions: \_\_\_\_\_

## CHILD'S DENTAL HISTORY

Name of General Dentist \_\_\_\_\_

Date of last visit \_\_\_\_\_ What was done? \_\_\_\_\_

Are any teeth sore today? Y N, If Yes, please explain \_\_\_\_\_

Have you had any injuries to the face, mouth or teeth? Y N, If Yes, please explain \_\_\_\_\_

Have you ever sucked your fingers or thumb? Y N, If Yes, until what age? \_\_\_\_\_

Do you breathe primarily through your mouth? Y N \_\_\_\_\_

Do you clench or grind your teeth? Y N, If Yes, please explain: \_\_\_\_\_

Is there clicking or pain on opening or closing the mouth? Y N, If Yes, please explain: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for providing the above information ☺