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invisalign



PATIENT PERSONAL INFORMATION FORM - CHILD

ACCT# _____ DATE _____

Last Name _____ First _____ MI _____ School _____

Preferred Name _____ Sex _____ Age _____ DOB _____ Patient Cell # _____

Mailing Address _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Siblings Name _____ DOB _____ Siblings Name _____ DOB _____

Siblings Name _____ DOB _____ Siblings Name _____ DOB _____

Mother's Name _____ SS# _____

Mother's Address _____ City/State _____ Zip _____

#'s Cell _____ Hm _____ Wk _____ Employer _____

Father's Name _____ SS# _____

Father's Address _____ City/State _____ Zip _____

#'s Cell _____ Hm _____ Wk _____ Employer _____

Who does patient live with _____ Is patient's last name different from yours Yes No

DENTAL INSURANCE

Insurance Co _____ Policy _____ Grp _____ Ortho Coverage Yes No

Subscriber Name _____ SS# _____ - _____ - _____ Birthdate _____

DENTAL HISTORY

Who recommended your child see an orthodontist? Dentist Friend _____ Other _____

Who referred you to our practice? Dentist Friend _____ Other _____

Has your child had or presently have any of the following habits:

Thumb/finger sucking Lip biting Snoring Mouth breathing Grinding of teeth at night

Have there been any injuries to the face, mouth or teeth? Yes No _____

Have you been informed of any missing or extra permanent teeth? Yes No _____

Are you aware of sores, lumps or irritated areas in your child's mouth? Yes No

Has an orthodontist been consulted previously? Yes No

If so, by whom _____ Date _____

Has your child been treated for:

Bad bite TMJ Periodontal Disease

If so, by whom _____

Do your child have any speech problems? Yes No

Is your child frightened or anxious about orthodontic treatment? Yes No

Is your child concerned about the appearance of his/her teeth? Yes No

Is there anything your child would like to change about his/her smile? Yes No

If so, what _____

Reason for consultation (Chief concern) _____

Has there ever been any orthodontic treatment for any other member of the family? Yes No

If so, who _____ Are you satisfied with the results? Yes No

Family dentist _____ Last cleaning _____

