MISO
ORTHODONTIC STUDIO

CHILD & TEEN PATIENTS

New Patient Form

A parent or guardian should complete this form. Your answers are confidential and help us plan your child's care.

> **Please email your completed form to hello@misoortho.com at least 72 hours before your appointment.**
> This is important so we can prepare for your appointment and know your insurance benefits.
> Fill it out on your computer and save it, or print it, complete it by hand, and send a clear photo or scan.

PATIENT INFORMATION

Child's name (first, middle, last) _____ Birth date _____

Nickname (if preferred) _____ Age _____ Sex ◯ Male ◯ Female School / grade _____

Home address _____ City, State, ZIP _____

General or pediatric dentist _____ How did you hear about our office? _____

Have we treated another family member? ◯ Yes ◯ No If yes, name _____

Has your child visited an orthodontist before? ◯ Yes ◯ No If yes, why _____

Main concern for this visit _____

Is there anything you would like to discuss with the doctor in private? ◯ Yes ◯ No

PARENT / GUARDIAN INFORMATION

Parent or guardian name _____ Relationship to child _____

Cell phone _____ Home phone _____ Email _____

Second parent or guardian, name and phone (optional) _____

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Insurance company		
Company phone		
Group or plan #		
Member ID #		
Insured's name		
Insured's birth date		
Relationship to patient		
Insured's employer		

Name _____

HEALTH HISTORY

Check all that apply to your child.

- ☐ ADD/ADHD or behavioral issues
- ☐ High or low blood pressure
- ☐ Seizures, epilepsy or stroke
- ☐ Cold sores or herpes
- ☐ Endocrine problems
- ☐ Heart condition, angina or murmur
- ☐ Hepatitis A, B or C
- ☐ Autism
- ☐ AIDS/HIV infection
- ☐ Artificial joints
- ☐ Cancer or tumors
- ☐ Diabetes or hypoglycemia
- ☐ Eye, hearing or speech impairment
- ☐ Arthritis
- ☐ Bone disorder or bisphosphonate use
- ☐ Asthma
- ☐ Allergies (list below)
- ☐ Heart valve disease or rheumatic fever
- ☐ Blood disorder or anemia
- ☐ Emotional disturbance
- ☐ Disability
- ☐ Radiation therapy
- ☐ Tuberculosis
- ☐ Other (list below)

Allergies

Current medications and doses

Other conditions not listed above

Is your child under a physician's care now? ◯ Yes ◯ No If yes, for what _____

Does your child have a history of major illness? ◯ Yes ◯ No If yes, please describe _____

Pediatrician or family physician _____ Phone _____ Date of last visit _____

Name _____

DENTAL HISTORY

Check all that apply to your child.

- ☐ Injury to face, mouth or teeth
- ☐ Tongue thrust
- ☐ Known extra permanent teeth
- ☐ Clenching or grinding teeth (day / night / both) _____
- ☐ Frequent headaches
- ☐ Muscle tenderness or stiffness in the jaw or neck
- ☐ Dizziness or ringing in the ears
- ☐ Thumb, finger or lip sucking habit
- ☐ Known missing permanent teeth
- ☐ Teeth removed year: _____
- ☐ Plays a musical instrument which: _____
- ☐ Pain, popping or locking when opening or closing the jaw
- ☐ Previous treatment for TMJ problems

SLEEP AND AIRWAY SCREEN

These questions help us check whether trouble breathing during sleep may be affecting your child's growth, behavior or treatment. They are a screen, not a diagnosis.

	YES	NO	NOT SURE
Does your child snore loudly 3 or more nights a week?	○	○	○
Have you seen your child stop breathing, choke or gasp during sleep?	○	○	○
Does your child breathe through the mouth, day or night, or sleep with the mouth open?	○	○	○
Is your child's sleep restless, with sweating or unusual positions (head tilted back, sitting up)?	○	○	○
Does your child wet the bed (age 5 and older)?	○	○	○
Does your child have trouble breathing through the nose, or often have a stuffy nose?	○	○	○
Is your child tired or hard to wake in the morning?	○	○	○
Does your child wake with headaches in the morning?	○	○	○
Is your child sleepy or dozing during the day (naps, at school)?	○	○	○
Does your child have trouble paying attention, seem hyperactive, or have behavior or school problems?	○	○	○
Have your child's tonsils or adenoids been removed, or has a doctor said they are enlarged?	○	○	○
Has your child been slow to grow or gain weight?	○	○	○
Does a parent or sibling have sleep apnea or loud snoring?	○	○	○

Name _____

DIAGNOSIS AND SLEEP STUDY

Has your child been diagnosed with ADHD?

◯ Yes ◯ No ◯ Being evaluated ◯ Not sure

If yes or being evaluated, diagnosed by _____ Takes ADHD medication? ◯ Yes ◯ No

Has your child been diagnosed with sleep apnea?

◯ Yes ◯ No ◯ Not sure

Has your child ever had a sleep study?

◯ Yes, overnight at a sleep center ◯ Yes, a home test only ◯ No ◯ Not sure

If yes, when and where _____

Has your child seen an ENT or sleep specialist for breathing or sleep concerns?

◯ Yes ◯ No ◯ Not sure

Name _____

If your child has had a sleep study, please send a copy of the report with this form or bring it to the first visit.

CONSENT AND SIGNATURE

I confirm that the information I have provided is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I understand that the sleep and airway questions are a screening only and not a diagnosis. I authorize the release of any information related to insurance claims, I consent to examination of my child by the doctor, and I authorize payment of any insurance benefits.

Parent or guardian signature (type your full name or sign by hand) _____ Date _____

FOR OFFICE USE ONLY

Number of Yes answers in the sleep and airway screen (clinician review; not a validated score) _____ / 13

Clinical findings ☐ Mouth breathing ☐ Mentalis strain ☐ Tonsils over 50% ☐ Ankyloglossia ☐ Dental wear ☐ Narrow palate

Sleep study report received ◯ Yes ◯ No ◯ N/A

Follow-up ☐ None ☐ Refer to physician / ENT / sleep medicine

Notes