

WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1

Tell Us About Your Child

Today's Date: ___/___/___ Male Female

Child's Name: _____
LAST FIRST MI

Nickname: _____ SS#: _____

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO #

CITY STATE ZIP

E-Mail Address: _____

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Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

CITY STATE ZIP

Previous Address: _____

CITY STATE ZIP

Hm #: (____) _____ DL #: _____

Employer: _____

Wk #: (____) _____ Ext: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____

Address: _____

CITY STATE ZIP

2

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: Single Widowed
 Married Divorced Separated

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Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

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Primary Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

CONTINUED ON BACK

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What are the main concerns that you would like orthodontics to accomplish? _____

Has your child ever been evaluated or had orthodontic treatment before? Yes No

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No

Does your child brush his / her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Has your child ever taken Phen-Fen? Yes No

(Also known as Redux or Pondimin) If yes, when? _____

Please describe your child's current physical health:

Good Fair Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____

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Has your child ever had any of the following medical problems?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD / ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps / Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Latex / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

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Does/did your child have any of the following habits?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching / Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking / Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb / Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |

Was your child breast fed? Y N

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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 services my child may need.

My method of payment will be _____

Signature of parent or guardian

Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of parent or guardian

Date

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____

Initials: _____ Date: _____