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: ______________

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

3 ☐ 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 #: ______________

4 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

5 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

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: __________

____

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

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

Please discuss any medical problems that your child has had:

____

____

____

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

Y N Clenching / Grinding Teeth	Y N Nursing Bottle
Y N Lip Sucking / Biting	Y N Speech Problems
Y N Mouth Breather	Y N Thumb / Finger Sucking
Y N Nail Biting	Y N Tongue Thrust

Was your child breast fed? Y N

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: __________

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