

WELCOME

TO OUR ORTHODONTIC PRACTICE

We would like to welcome you and your child to our office. Our goal is to make your 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.

TELL US ABOUT YOUR CHILD

Today's Date _____ Male Female
 Child's Name: _____
LAST FIRST MI
 Nickname: _____ SS# _____
 Child's Birth Date: ___/___/___ Child's Age: _____
 School: _____ Grade: _____
 Hobbies / Sports: _____
 Child's Home #: _____
 Child's Home Address: _____
APT/CONDO#
CITY STATE ZIP

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
 Billing Address: _____

CITY STATE ZIP
 Hm#: (____) _____ DL#: _____
 Employer: _____
 Wk#: (____) _____ Ext: _____
 Email: _____

WHO WILL BE MAKING APPOINTMENTS?

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

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____
 Do you have legal custody of this child: _____
 Whom may we thank for referring you? _____
 List brothers / sisters and birth dates: _____

 General Dentist: _____
 Last Visit Date: _____
 Parents' Marital Status: Single Widowed
 Married Divorced Separated

MOTHER'S INFORMATION Step Mother Guardian

Name: _____ Birth Date: ___/___/___
 Wk#: (____) _____ Ext: _____ Hm#: (____) _____
 Employer: _____
 How Long at Current Job: _____ Job Title: _____
 SS# _____ DL#: _____

FATHER'S INFORMATION Step Father Guardian

Name: _____ Birth Date: ___/___/___
 Wk#: (____) _____ Ext: _____ Hm#: (____) _____
 Employer: _____
 How Long at Current Job: _____ Job Title: _____
 SS# _____ DL#: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic 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 Birth Date: ___/___/___ SS#: _____
 Policy Owner's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic 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 Birth Date: ___/___/___ SS#: _____
 Policy Owner's Employer: _____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

Has your child ever been evaluated for 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

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 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 Allergy to any Drugs | Y N Handicaps / Disabilities |
| Y N Allergy to Latex / Metals | Y N Hearing Impairment |
| Y N Allergy to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Asthma | Y N HIV+ / AIDS |
| Y N Cancer | Y N Kidney / Liver Problems |
| Y N Congenital Heart Defect | Y N Rheumatic / Scarlet Fever |
| 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 Habits |
| 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 |

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Phone:(____) _____

Address: _____

CITY

STATE

ZIP

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 any necessary dental services my child may need.

Signature

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

Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of parent or guardian

Date

The Parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

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

Doctors' Comments:

Initials: _____ Date: _____
