WELCOME

To Your Orthodontist!

Tell Us About Your Child

Today's Date____/____/____ Nickname _____

Child's Name_____
LAST FIRST MI

Child's Birthdate ____/____/____ Child's Age_____ ☐ M ☐ F

E-mail Address _____

School _____ Grade: _____

Hobbies/sports: _____

Child's Hm #: (_____)_____ SS # _____

Child's Home Address _____

CITY STATE ZIP

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐Y ☐N

Whom may we thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____

Dentist Ph: (_____)_____ Last Visit Date: _____

Relative or friend not living with you:

Name: _____ Ph: (_____) _____

Address: _____

CITY STATE ZIP

Parent's Information

Who is responsible for account?_____ Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced ☐Separated

☐ Father ☐ Stepfather ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____)_____

SS #: _____ DL #: _____

Wk : (_____) _____ Cell #: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

CITY STATE ZIP

Ins. Ph : (_____)_____ Insured's ID #: _____

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

☐ Mother ☐ Stepmother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____)_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Cell #: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

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CITY STATE ZIP

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Authorization

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. 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

SIGNATURE OF PARENT OR GUARDIAN DATE

CONTINUED ON BACK

Dental and Medical History

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

Does the child require antibiotics before dental treatment? ☐ Y ☐ N

Have adenoids or tonsils been removed? ☐ Y ☐ N

Does your child have any missing or extra permanent teeth? ☐ Y ☐ N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Y ☐ N

Does the child brush teeth daily? ☐ Y ☐ N Floss daily? ☐ Y ☐ N

Child's Physician: _____

Ph #: (_____) _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

GIRLS: Has menstruation begun? ☐ Y ☐ N

Indicate the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____ _____

_____ _____

Does your child have allergies to any of the following?

Latex ☐ Y ☐ N Nickel/Metals ☐ Y ☐ N Plastic ☐ Y ☐ N

Please list any other allergies that the child may have:

_____ _____

_____ _____

Has the child experienced any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hemophilia
Y	N	Any Hospital Stays/Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Problems
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Prosthetics
Y	N	Convulsions	Y	N	Rheumatic Fever
Y	N	Diabetes	Y	N	Scarlet Fever
Y	N	Epilepsy	Y	N	Sickle Cell Disease/Traits
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Has the child ever taken any diet pills such as Phen-Fen? ☐ Y ☐ N

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

Are the child's immunizations current? ☐ Y ☐ N

Would you like to discuss anything with the Doctor in private? ☐ Y ☐ N

Please list any serious medical problems the child has had:

_____

_____

_____

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

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

List any musical instruments played: _____

_____

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.

I understand that the information I have given is correct to the best of my knowledge, 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 authorize the dental staff to perform the necessary dental/orthodontic services that my child may need.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

OFFICE USE ONLY

Doctor's Comments: _____

_____

_____

_____

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

_____

SIGNATURE OF DOCTOR DATE

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: _____

_____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

DOCTOR SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

DOCTOR SIGNATURE DATE