WELCOME TO THE ORTHODONTIST

Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____ ☐ M ☐ F
LAST FIRST MI

Birthdate: ___/___/___ Age: ____ SS #: _____

School: _____ Grade: ____

Hobbies / Sports: _____

Child's Home # (____) _____

Child's Home Address: _____

_____
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 other family members seen by us _____

_____

General Dentist: _____

Date of last cleaning / visit: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 Parental Information

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____ Birthdate ___/___/___

Wk # (____) _____ Hm # (____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____ Birthdate ___/___/___

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

Who is responsible for making appointments?

Name: _____ Wk # (____) _____

Cell # (____) _____ Hm # (____) _____

5 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 Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

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 Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

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What would you like orthodontics to accomplish?

Has your child ever taken Phen-Fen? (Redux or Pondimin) If yes, when? ☐Y ☐N

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

List any musical instruments played:

Have adenoids or tonsils been removed? ☐Y ☐N

Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N

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

Does your child brush his / her teeth daily? ☐Y ☐N

Does your child floss his / her teeth daily? ☐Y ☐N

Child's Physician:

Phone # (_____) Date of last visit:

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

Has puberty begun? ☐Y ☐N

Girls - Has menstruation begun? ☐Y ☐N

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:

Latex Y N Metals/Nickel Y N Plastics Y N

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

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

Please discuss any medical problems that your child has had:

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Has your child ever experienced any of the following?

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 Ph # (_____)

Address

CITY STATE ZIP

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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 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 that my child may need.

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

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 payment of the group insurance benefits directly to this office.

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

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

Doctor's Comments: Initials: Date: