WELCOME

Tell Us About Your Child

Today's Date:

Name:
Last First M.I.

Birthdate: ___ **Male** ___ **Female**

Nickname:

Home #:

Address:

City State Zip

School: **Grade:**

Sports/Hobbies/Activities:

General Information

Whom do we thank for referring you?

Dentist: **Date of Last Visit:**

Dentist Phone #:

Physician: **Date of Last Visit:**

Physician Phone #:

He/She currently under the care of a doctor? **Y** **N**

Preferred Mail Method: *Circle* **Email** **Regular Mail**

Parent/Guardian Information

Who is *financially* responsible for the account:

Parent's Marital Status: *Circle* **Single** **Married** **Partnered** **Widow** **Divorced** **Separated**

☐ **Father** ☐ **Stepfather** ☐ **Guardian** ☐ _____

Name: **Birthdate:**

Address: (If different from Child's)

City: **State:** **Zip:**

Cell#: **Wk#:** **Ext:**

Email: **SSN:**

Employer:

Employer Address **City** **State** **Zip**

Dental Insurance Co. Name:

Circle **Primary Policy** **Secondary Policy**

Member ID # (or SSN if not applicable):

Insurance Address **City** **State** **Zip**

Phone #: **Group #:**

☐ **Mother** ☐ **Stepmother** ☐ **Guardian** ☐ _____

Name: **Birthdate:**

Address: (If different from Child's)

City: **State:** **Zip:**

Cell#: **Wk#:** **Ext:**

Email: **SSN:**

Employer:

Employer Address **City** **State** **Zip**

Dental Insurance Co. Name:

Circle **Primary Policy** **Secondary Policy**

Member ID # (or SSN if not applicable):

Insurance Address **City** **State** **Zip**

Phone #: **Group #:**

Authorization

I understand that I am responsible for payment of services at the time they are rendered. Insurance claims will be submitted and payment from the insurance company will be sent to the insured. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I further authorize the use of this signature on all my insurance submissions and credit card payments, whether manual or electronic.

Signature of Parent/Guardian Date

Dental & Medical History

What are your 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

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 his/her teeth daily? Y N

Floss his/her teeth daily? Y N

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

Please list all drugs that the child is currently taking:

Has the child experienced the following medical problems?

Abnormal Bleeding	Y	N	Hearing Impairment	Y	N
ADD/ADHD	Y	N	Heart Murmur	Y	N
AIDS/HIV+	Y	N	Hemophilia	Y	N
Any Hospitalizations	Y	N	Hepatitis	Y	N
Artificial bones/joints/etc	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	Y	N
Handicaps/Disabilities	Y	N	Tuberculosis (TB)	Y	N

Are the child's immunizations current? Y N

Anything you would like to discuss with the Doctor in private? Y N

Please discuss any serious medical problems that child has had:

_____

_____

_____

Mouth Breather	Y	N	Tongue Thrust	Y	N
Clenching/Grinding	Y	N	Thumb/Finger Sucking	Y	N
Nail Biter	Y	N	Used Pacifier	Y	N
Speech Problem	Y	N			

List any musical instruments played:

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

_____

Latex Y N **Nickel/Metals Y N** **Plastic Y N**

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 help 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 my child may need.

Signature of Parent/Guardian Date

OFFICE USE ONLY

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

Doctor's Comments:

Signature of Orthodontist Date