Welcome to Our Office

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First Mi

Prefers to be called: _____ ○ Male ○ Female

Birthdate: _____/_____/_____ Age: _____ SS #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

Home #: _____ Cell/Other #: _____

E-mail Address: _____

School: _____ Grade: _____

Hobbies / Sports: _____

_____

General Information

Who is accompanying the child today?

_____
Name Relation

Do you have legal custody of this child? ○ Yes ○ No

Whom may we thank for referring you? _____

Other siblings / ages: _____

General Dentist: _____ Last Dental Visit: _____

Dentist's Phone #: _____

Relative or Friend not living with you:

Name: _____ Phone #: _____

Address: _____

_____
City State Zip

Parent Information

Who is responsible for account? _____ Parent's Marital Status: ○ Single ○ Married ○ Partnered ○ Widowed ○ Divorced ○ Separated

○ Father ○ Step Father ○ Guardian

Name: _____ Birthdate: ____/____/____

Address (If different than Child's): _____
Apt/Condo #

_____
City State Zip

Home #: _____ Cell / Other #: _____

SS #: _____ DL# _____

E-mail: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Work #: _____ Ext: _____

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____ Insured's ID #: _____

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

○ Mother ○ Step Mother ○ Guardian

Name: _____ Birthdate: ____/____/____

Address (If different than Child's): _____
Apt/Condo #

_____
City State Zip

Home #: _____ Cell / Other #: _____

SS #: _____ DL# _____

E-mail: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Work #: _____ Ext: _____

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Insurance Address: _____

_____

Insurance Phone #: _____ Insured's ID #: _____

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

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. 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. 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

Dental & Medical History

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

_____

_____

Has your child ever had or been evaluated for orthodontic treatment? ○ Yes ○ No

Have there been any injuries to the face, mouth, teeth or chin? ○ Yes ○ No

Does the child require antibiotics before dental treatment? ○ Yes ○ No

Have adenoids or tonsils been removed? ○ Yes ○ No

Does your child have 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

Does your child floss his / her teeth daily? ○ Yes ○ No

Is your child currently under the care of a physician? ○ Yes ○ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Has puberty begun? ○ Yes ○ No

Has menstruation begun? ○ Yes ○ No

Please describe the child's current physical status: ○ Good ○ Fair ○ Poor

Please list all drugs that the child is currently taking: _____

_____

Is your child allergic to any of the following:

Y N Latex Y N Nickel / Metals Y N Plastics

Please list any other drugs / materials that your child is allergic to:

_____

_____

Has your child experienced the following medical problems?

Y N Abnormal Bleeding / Hemophilia	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 / Chemotherapy	Y N Mitral Valve Prolapse
Y N Congenital Heart Disease	Y N Prosthetics
Y N Convulsions	Y N Rheumatic / Scarlet Fever
Y N Diabetes	Y N Sickle Cell Disease / Traits
Y N Epilepsy	Y N Sinus Problems
Y N Handicaps / Disabilities	Y N Tuberculosis (TB)

Has your child ever taken Phen-Fen (Redux or Pondimin)? ○ Yes ○ No

If so, when? _____

Are the child's immunizations current? ○ Yes ○ No

Anything you would like to discuss with the Doctor in private? ○ Yes ○ No

Please discuss 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 Habit
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 Used Pacifier

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 my child may need.

_____

Signature of Parent or Guardiam Date

OFFICE USE ONLY

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

_____

Signature of Dentist Date

Doctor's Comments: _____

_____

Medical History Update

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

○ Yes ○ No If yes, please explain: _____

_____

_____

Patient Signature Date Doctor Initials

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

○ Yes ○ No If yes, please explain: _____

_____

_____

Patient Signature Date Doctor Initials

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_____

_____

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