6

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

____

Has your child ever been evaluated 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

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? ______________ ☐ 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/things that your child is allergic to:

____

7

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 / Valves	Y N HIV+ / AIDS
	Y N Kidney Problems
Y N Asperger Syndrome	Y N Liver Problems
Y N Asthma	Y N Lupus
Y N Autism	Y N Rheumatic/Scarlet Fever
Y N Cancer	Y N Sickle Cell Disease/ Traits
Y N Congenital Heart Defect	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

____

8

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

Y N Clenching/Grinding Teeth	Y N Nursing Bottle
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

Was your child breast fed? Y N

9

I affirm that the information I have given is correct to the best of my knowledge. 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 my child may need. If this office accepts insurance, I assign directly to Dr. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

My method of payment will be: ______________ ______________________ ______________

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

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 OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments: Initials: ______________ Date: ________

____

____

____

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WELCOME TO THE ORTHODONTIST

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

1 Tell Us About Your Child

Today's Date: ___/___/___ ☐ Male ☐ Female

Child's Name: ______________________
LAST FIRST MI

Nickname: ______________________ SS#: ______________________
CHILD PREFERS TO BE CALLED

Child's Birthdate: ___/___/___ Child's Age: ______________________

School: ______________________ Grade: ______________________

Hobbies / Sports: ______________________

Child's Home #: (___) ______________________

Child's Home Address: ______________________
APT/CONDO #

____
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 brothers / sisters with age: ______________________

____

General Dentist: ______________________

Last Visit Date: ______________________

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

3

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: ______________________ Birthdate: ______________________

Email Address: ______________________

Cell #: (____) ______________________ Hm #: (____) ______________________

Employer: ______________________ Wk #: (____) ______________________

SS #: ______________________ DL #: ______________________

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: ______________________ Birthdate: ______________________

Email Address: ______________________

Cell #: (____) ______________________ Hm #: (____) ______________________

Employer: ______________________ Wk #: (____) ______________________

SS #: ______________________ DL #: ______________________

4 Person Responsible For Account

Name: ______________________ Relation: ______________________

Billing Address: ______________________

____
CITY STATE ZIP

Previous Address: ______________________

____
CITY STATE ZIP

Hm #: (___) ______________________ DL #: ______________________

Employer: ______________________

Wk #: (___) ______________________ Ext: ____ SS #: ______________________

Who is responsible for making appointments?

Name: ______________________

Wk #: (___) ______________________ Ext: ____ Hm #: (___) ______________________

Neighbor or Relative not living with you.

Name: ______________________ Phone: (___) ______________________

Address: ______________________

____
CITY STATE ZIP

5

Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho 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: ___/___/___ SS #: ______________________

Policy Owner's Employer: ______________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho 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: ___/___/___ SS #: ______________________

Policy Owner's Employer: ______________________

CONTINUED ON BACK