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: ________ Nickname: ________ (CHILD PREFERS TO BE CALLED)

Child's Name: ________ (LAST / FIRST / MI)

E-mail Address: ________ SS#: ________

Birthdate: ___/___/___ Age: ____ ☐ Male ☐ Female

School: ________ Grade: ________

Hobbies / Sports: ________

Child's Home #: (____) ________

Child's Home Address: ________ (APT/CONDO #)

________ (CITY / STATE / ZIP)

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 ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: ________ Birthdate: ___/___/___

Email Address: ________

Cell #: (____) ________ Hm #: (____) ________

Employer: ________ Wk #: (____) ________

SS #: ________ DL #: ________

☐ Father's Information: ☐ Step Father ☐ 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 #: ________

Cell # (____) ________ SS #: ________

Employer: ________ Wk # (____) ________ Ext: ____

Who is responsible for making appointments?

Name: ________

Wk # (____) ________ Ext: ____ 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: ________

CONTINUED ON BACK

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

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If yes, when? ______

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

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: ______

Y N **Latex** Y N **Metals/Nickel** Y N **Plastics**

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

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

Please discuss any medical problems that your child has had:

______

8 Has your child ever experienced any of the following?

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

Neighbor or Relative not living with you.
Name ______ **Phone** (___) ______
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 of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

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 ______

I authorize the dental staff to perform the necessary dental services my child may need.

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. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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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