For office use only
____

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

TELL US ABOUT YOUR CHILD

Today's Date__________________ ❒ Male ❒ Female

Child's Name:______________________________
LAST FIRST MI

Nickname:______________________________

Child's Birth Date: ____/____/____ Child's Age:________

School:____________________ Grade:________

Hobbies / Sports:______________________________

Child's Home #:______________________________

Child's Home Address:______________________________
APT/CONDO#

____
CITY STATE ZIP

PERSON RESPONSIBLE FOR ACCOUNT

Name:____________________Relation:__________

Billing Address: ______________________________

____
CITY STATE ZIP

Hm#: (____)______________________________

Employer:______________________________

Wk#:(____)____________________Ext:________

SS#: ______________________________

Parents' Marital Status: ❒ Single ❒ Widowed ❒ Married ❒ Divorced ❒ Separated

MOTHER'S INFORMATION

❒ Step Mother ❒ Guardian

Name:____________________Birth Date:___/___/___

Wk#:(____)________Ext:_____Hm#: (____)__________

Email: ______________________________

Employer:______________________________

How Long at Current Job:______ Job Title:____________

FATHER'S INFORMATION

❒ Step Father ❒ Guardian

Name:____________________Birth Date:___/___/___

Wk#:(____)________Ext:_____Hm#: (____)__________

Email: ______________________________

Employer:______________________________

How Long at Current Job:______ Job Title:____________

List brothers / sisters and birth dates:____________________

____

____

____

Whom may we thank for referring you?____________________

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 Birth Date:___/___/___SS#:____________

Policy Owner's Employer:______________________________

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 Birth Date:___/___/___SS#:____________

Policy Owner's Employer:______________________________

CONTINUED ON BACK

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

____
____
____
____
____
____

Has your child ever been evaluated for 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

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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

Child's Dentist: ______________________________

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 that your child is allergic to:

____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N Allergy to any Drugs
Y N Allergy to Latex / Metals
Y N Allergy to Plastic
Y N Any Hospital Stays
Y N Any Operations
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 Rheumatic / Scarlet Fever
Y N Tuberculosis (TB)

Please Discuss any medical problems that your child has had:

____
____
____

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

____
Signature **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.

____
Signature of parent or guardian **Date**

The Parent or Guardian who accompanies the child is responsible for payment. Our office 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.

Doctors' Comments: Initials: __________ Date:______________

____
____