

# WELCOME

## To Your Orthodontist!

### Tell Us About Your Child

Today's Date: \_\_\_/\_\_\_/\_\_\_ Nickname: \_\_\_\_\_  
**Child's Name:** \_\_\_\_\_  
Last First MI  
Child's Birthdate: \_\_\_/\_\_\_/\_\_\_ Child's Age: \_\_\_ Gender: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Hobbies/sports: \_\_\_\_\_  
Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
Apt / Condo # \_\_\_\_\_  
City State Zip

### 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 Visit Date: \_\_\_\_\_  
Dentist's Phone: (\_\_\_\_) \_\_\_\_\_  
Relative or Friend not living with you:  
Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
City State Zip

### Parent's Information

Who is responsible for account? \_\_\_\_\_ Parent's Marital Status

Single  Married  Partnered  Widowed  Divorced  Separated

Mother/Father Step Parent Guardian

Mother/Father Step Parent Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Address: (If different than Child's) Hm #: (\_\_\_\_) \_\_\_\_\_

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SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

City State Zip

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

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Insurance Co. Name: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City State Zip

City State Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

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Group # (Plan, Local, or Policy #): \_\_\_\_\_

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### 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. 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 the dentist to release all information necessary to secure the payment of benefits. And 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

CONTINUED ON BACK



# Dental & Medical History

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

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 the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?

Yes  No

Does the child brush his/her teeth daily?

Yes  No

Floss his/her teeth daily?

Yes  No

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Is the child currently under the care of a physician?

Yes  No

Has puberty begun?

Yes  No

Has menstruation begun?

Yes  No

Please describe the child's current physical health:

Good  Fair  Poor

Please list all drugs that the child is currently taking:

\_\_\_\_\_

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

\_\_\_\_\_

Latex  Nickel/Metals  Plastic

Has the child experienced the following medical problems?

- |   |                                |   |                            |
|---|--------------------------------|---|----------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding              | <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing Impairment         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | ADD/ADHD                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | AIDS/HIV+                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any Hospital Stays/Operations  | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems            |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma                         | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer                         | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect        | <input type="checkbox"/> Y <input type="checkbox"/> N | Prosthetics                |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions                    | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic Fever            |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet Fever              |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell Disease/Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps/Disabilities         | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB)          |

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin.) If so, when?  Yes  No

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 experience any of the following?

- |   |                          |   |                       |
|---|--------------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Breast Fed               | <input type="checkbox"/> Y <input type="checkbox"/> N | Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N | Speech Problems       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Lip Sucking/Biting       | <input type="checkbox"/> Y <input type="checkbox"/> N | Thumb/Finger Sucking  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth Breather           | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue Thrust         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Nail Biting              | <input type="checkbox"/> Y <input type="checkbox"/> 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 Guardian Date

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

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

\_\_\_\_\_  
Signature of Dentist Date

Dentist's Comments: \_\_\_\_\_

## Medical History Update

Has there been any change in your child's health status since their last visit?  Y  N  
If Yes, please explain. \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Dentist Signature Date

Has there been any change in your child's health status since their last visit?  Y  N  
If Yes, please explain. \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Dentist Signature Date