# 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: ___ ☐ Male ☐ Female

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

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate:___/___/___

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

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____Cell/Other #: (_____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

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

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

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

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

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate:___/___/___

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

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____Cell/Other #: (_____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

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

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

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. 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:**

_____

_____

Y N Latex Y N Nickel/Metals Y N Plastic

**Has the child experienced the following medical problems?**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | 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 | Y | N | Mitral Valve Prolapse |
| Y | N | Congenital Heart Defect | Y | N | Prosthetics |
| Y | N | Convulsions | Y | N | Rheumatic Fever |
| Y | N | Diabetes | Y | N | Scarlet Fever |
| Y | N | Epilepsy | Y | N | Sickle Cell Disease/Traits |
| Y | N | Handicaps/Disabilities | Y | N | Tuberculosis (TB) |

Has the child ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin.) 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 Habits |
| 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 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