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Specialist in Orthodontics

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We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. The better we are able to communicate, the better care we can provide for you.

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____

Child's Birthdate: _____/_____/_____ Age: _____

Child's Home Address: _____

_____
City State Zip

HM #: _____ WK #: _____ Cell#: _____

Child's school: _____ Grade: _____

Hobbies/Sports: _____

Brothers/Sisters with ages: _____

_____

Other family members seen by our office (present & past):

_____

General Dentist: _____

Date of Last Visit: _____

Whom May We Thank For Referring You?

_____

Parent's Information

Mother's Information: SSN: _____ D.O.B.: _____

Name: _____

Address: _____

HM#: _____ WK#: _____ Cell#: _____

Father's Information: SSN: _____ D.O.B.: _____

Name: _____

Address: _____

HM#: _____ WK# : _____ Cell#: _____

Who is responsible for making appointments?

_____

Person Responsible for Account

Name: _____ Relation: _____

Address: _____

HM#: _____ WK#: _____ Cell#: _____

Employer: _____

Social Security # (***required***): _____

Primary Orthodontic Insurance

Orthodontic Coverage? ___ YES ___ NO

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____/_____/_____

Social Security # (***required***): _____

Insured's Employer: _____

Employer Address: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Secondary Orthodontic Insurance

Orthodontic Coverage? ___ YES ___ NO

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____/_____/_____

Social Security # (***required***): _____

Insured's Employer: _____

Employer Address: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

CONTINUED ON BACK OF FORM

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

_____

_____

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

Have the adenoids or tonsils been removed?

___ YES ___ NO

Have you ever been informed of any missing or extra permanent teeth?

___ YES ___ NO

Has your child ever experienced pain/discomfort in his/her jaw joint (TMJ/TMD)?

___ YES ___ NO

Your child's current dental health is:

___ Good ___ Fair ___ Poor

Has your child ever had a serious/difficult problem associated with any previous dental work?

___ YES ___ NO

Please describe your child's physical health:

___ Good ___ Fair ___ Poor

Does your child use tobacco or tobacco products?

___ YES ___ NO

Is your child currently under the care of a physician?

___ YES ___ NO

If yes, please explain: _____

_____

Please list all drugs, including over-the-counter medications, that your child is currently taking: _____

_____

Please list all drug allergies: _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictness of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the orthodontic team to perform the necessary dental services that my child may need.

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

Y N Seasonal Allergies
Y N Allergies to plastic
Y N Allergies to Latex/Metals
Y N Diabetes
Y N Rheumatic Fever
Y N Heart Murmur
Y N Congenital Heart Defect
Y N Heart Attack/Stroke
Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N High/Low Blood Pressure
Y N Blood Transfusion
Y N Anemia/Radiation Treatment
Y N Surgeries
Y N Hospitalizations
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Mono
Y N Arthritis
Y N Thyroid Disease
Y N Ulcers/Colitis
Y N Emphysema/Glaucoma

Y N Artificial Bones/Joints
Y N Bone Disorders
Y N Cerebral Palsy
Y N Hemophillia
Y N Abnormal Bleeding
Y N Convulsions/Epilepsy
Y N HIV +/AIDS
Y N Venereal Disease
Y N Drug/Alcohol Abuse
Y N Difficulty Breathing
Y N Sinus Problems
Y N Shingles
Y N Fever Blisters
Y N Headaches
Y N Cancer/Chemotherapy
Y N Kidney/Liver Problem
Y N Cleft Lip/Cleft Palate
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Psychiatric Problems
Y N Endocrine Problems
Y N Nutritional Problems
Y N Fainting or Dizziness

Please discuss any other medical problems that your child has:

_____

_____

_____

Did or does your child currently have any of the following Habits?

Y N Thumb / Finger Sucking
Y N Lip Sucking/Biting
Y N Clenching/Grinding
Y N Mouth Breathing
Y N Speech Problems
Y N Nail Biting
Y N Tongue Thrust

Please give us an e-mail address for potential appointment confirmation in the future: _____

_____
Signature of Parent or Legal Guardian Date

_____
Relationship to patient