



Welcome

1 Tell Us About Your Child

Today's Date _____ Nickname _____
 Child's Name _____
 Birthdate ____/____/____ Age: _____ Male Female
 School _____ Grade _____
 Hobbies/Sports _____
 Child's Home # (____) _____ Cell # _____
 Child's Home Address _____
 Apt # _____
 City _____ State _____ Zip _____

Email Address: _____

2 Who is With Your Child Today?

Name _____ Relationship _____
 Do you have legal custody of this child? Yes No
 Whom may we thank for referring you? _____
 List brothers/sisters with age: _____

 General Dentist: _____
 Parent's Marital Status: Single Partnered Divorced
 Married Separated Widowed

3 Responsible Party Information

Name _____
 Mailing Address _____
 How long at this address(____) Relationship to Patient _____
 Hm # (____) _____ Cell # _____
 Wk # (____) _____ Ext. _____
 Previous Address (if less than 3 years) _____
 SS# _____ Birth Date _____
 Employer _____
 Occupation _____ No. Years Employed _____
 Spouse's Name _____
 Relationship to Patient _____
 Spouse's Employer _____
 Occupation _____ No. Years Employed _____
 SS# _____ Date of Birth _____

4 Personal Email

(For emailing appointment reminders ONLY)

5 Person Responsible for Account

Name _____ Relationship _____
 SS# _____
 Billing Address _____

 Hm # (____) _____ Cell # _____
 Employer _____
 Wk # (____) _____ Ext. _____

6 Primary Orthodontic Insurance

Orthodontic Coverage? Yes No
 Insurance Co. Name _____
 Insurance Co. Address _____
 Insurance Co. City & State _____
 Insurance Co. Phone # (____) _____
 Group /ID# _____
 Policy Owner's Name _____
 SS# _____
 Relationship to Patient _____
 Policy Owner's Employer _____
 Policy Owner's Birthdate ____/____/____

Secondary Orthodontic Insurance

Insurance Co. Name _____
 Insurance Co. Address _____
 Insurance Co. City & State _____
 Insurance Co. Phone # (____) _____
 Group # (Plan, Local or Policy #) _____
 Policy Owner's Name _____
 SS# _____
 Relationship to Patient _____
 Policy Owner's Employer _____
 Policy Owner's Birthdate ____/____/____

7 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

List any musical instruments played _____

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 # (____) _____

Is your child currently under the care of a physician? 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

8 **Has Your Child Ever Had Any of the Following Medical Problems?**

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

Please discuss any medical problems that your child has had: _____

9 **Has Your Child Ever Had Any of the Following Medical Problems?**

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

Name of nearest Relative or Neighbor not living with you
Name _____
Phone (____) _____ Cell (____) _____
Address _____

City State Zip

10 I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

- 1) I authorize the dental staff to perform the necessary dental services my child may need
- 2) We will file your insurance claim for you. 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.
- 3) **Notice of Privacy Practice:** You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes.
- 4) I understand that where appropriate, credit bureau reports may be obtained.

Signature for items 1, 2, 3, & 4

Signature of parent or guardian Date