WELCOME TO THE ORTHODONTIST

TELL US ABOUT YOUR CHILD

Today's Date: ____/____/____ ❑Male ❑Female

Child's Name: _____

I prefer to be called: _____

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

Child's Home Phone #: ( ) _____

Child's Home Address: _____

City/State/Zip: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Whom may we thank for referring you? _____

General Dentist: _____

Last Visit Date: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Birthdate: ____/____/____

Home Phone #: ( ) _____

Home Address: _____

_____

Employer: _____

Work Phone #: ( ) _____ ext._____

Cell Phone #: ( ) _____

May we contact you at work? ❑YES ❑NO

PARENT/GUARDIAN INFORMATION

Name: _____ Birthdate: ____/____/____

Home Phone #: ( ) _____

Home Address: _____

_____

Employer: _____

Work Phone #: ( ) _____ ext._____

Cell Phone #: ( ) _____

May we contact you at work? ❑YES ❑NO

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑YES ❑NO

List brothers / sisters with age: _____

_____

Parent's Martial Status: ❑ Single ❑ Widowed

❑ Married ❑ Divorced ❑ Separated

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

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone #: ( ) _____

Address: _____

_____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑YES ❑NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

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

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____

ID Number: _____

Policy Holder's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑YES ❑NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

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

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____

ID Number: _____

Policy Holder's Employer: _____

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.

CONTINUED ON BACK ▶▶▶

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: _____

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

Child's Physician: _____

Phone #: ( ) _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ❑ YES ❑NO

Has puberty begun? ❑ YES ❑NO

Please describe your child's current physical health:

❑Good ❑Fair ❑Poor

Please list all medications that your child is currently taking: _____

_____

Please list all medications that your child is ALLERGIC to:

_____

_____

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

Y N Abnormal Bleeding	Y N Diabetes
Y N Allergies to any Medications	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 Asthma	Y N HIV+ / AIDS
Y N Cancer	Y N Kidney / Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic/Scarlet Fever
Y N Convulsions / Epilepsy	Y N Tuberculosis (TB)

Please describe any medical problems that your child has had:

_____

_____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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

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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 the necessary dental services my child may need.

_____

Signature of parent or guardian Date

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 of the credit reporting services.

_____

Signature of parent or guardian Date

Thank You!