



We would like to welcome you and your child to our office. Our mission is to enhance the lives of our patients and their families by providing exceptional orthodontic care with excellent customer service in a safe and inviting atmosphere

Tell Us About Your Child

Male Female

Child's Name: _____

Last First Mi

Nickname: _____ SS#: _____

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

Child's Home #: (_____) _____

Child's Home Address: _____

Apt/Condo#

City State Zip

General Information

Whom may we thank for referring you? _____

List brothers / sisters with age: _____

General Dentist: _____

Last Visit Date: _____

Parent's Martial Status: Single Widowed

Married Divorced Separated

Mother's Information Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Do you have legal custody of this child? Yes No

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Cell #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ E-mail: _____

Father's Information Step Father Guardian

Name: _____ Birthdate: ___/___/___

Do you have legal custody of this child? Yes No

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Cell #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ E-mail: _____

Responsible Party

Name: _____ Relation: _____

Billing Address: _____

City State Zip

How long at this address: _____

Previous Address (if less than three years): _____

City State Zip

Hm #: (____) _____ DL #: _____

Employer: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Emergency

Name: _____ Phone: (____) _____

Address: _____

City State Zip

Dental Insurance

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Secondary Insurance

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

I understand where appropriate, credit bureau reports may be obtained.

Continued on Back

What are your specific concerns regarding your child's teeth?

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? _____

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 twice daily? Yes No

Floss his / her teeth daily? Yes No

Is your child currently under the care of a physician? Yes No

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

Has puberty begun? Yes No

Has menstruation begun? (Girls) 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 any allergies: _____

Has your child ever had any of the following?

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

If you circled yes to any of these please explain further if necessary:

Does / did your child have any of the following 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 | |

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 that I have given today is correct and to the best of my knowledge. I also understand that is information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary services that I may need during diagnosis and treatment, with my informed consent

Signature

Date

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MEDICAL HISTORY UPDATE

Has there been any change in your health since you last visit? Y N

If Yes, please explain. _____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

Signature Date

Has there been any change in your health since you last visit? Y N

If Yes, please explain. _____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

Signature Date