Tell us about your child

Today's Date:_____ ___ Male ___ Female
Child's Name: _____
Last First MI
Nickname: _____ SS # _____
Child's Birthdate: __ / __ / __ Child's Age: _____
School: _____ Grade: _____
Hobbies / Sports: _____
Child's Home #: (___)_____
Child's Home Address: _____
_____
City State Zip

Who is Accompanying Your Child Today ?

Name: _____ Relation: _____
Do you have legal custody of this child? __ Yes __ No
Whom may we Thank for referring you? _____
List brothers / sisters with age: _____
_____
General Dentist: _____
Last vist date:_____
Parent's Marital Status __ Single __ Married __Widowed __ Separated __ Divorced _
Person Responsible for Account: _____
Billing Address: _____

Mother's Information: __ Step mother __ Guardian
Name: _____ Birthdate: ____/ ____/ ____
Wk #:(___)_____ Ext: _____ Home #: (___)_____
E-mail Address: _____
Employer: _____
How long at current job: _____ Job Title: _____
SS #: _____

Father's Information: __ Step father __ Guardian
Name: _____ Birthdate: ____/ ____/ ____
Wk #:(___)_____ Ext: _____ Home #: (___)_____
E-mail Address: _____
Employer: _____
How long at current job: _____ Job Title: _____
SS #: _____

Orthodontic Insurance - Primary Orthodontic coverage ___ yes ___ no
Insurance Co. Name:_____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, local or policy #): _____
Relationship to Patient: _____

Policy's Owner's Birthdate: __/____/____ SS #: _____
Policy Owner's Employer: _____

Orthodontic Insurance - Secondary Orthodontic coverage ___yes ___ no
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, local or policy #): _____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/____/____ SS #: _____
Policy Owner's Employer: _____

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

Has your child ever been evaluated or had orthodontic treatment before? __ Y__ N
Have there been any injuries to the face, mouth, teeth or chin? __ Y __ N
List any musical instruments played: _____
Have adenoids or tonsils been removed? __ Y __ N
Has your child been informed of any missing or extra permanent teeth __ Y __ N
Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? __ Y __ N
Does your child brush his / her teeth daily? __ Y __ N
Child's Physician: _____
Phone #: _____Date of last visit: _____
Is your child currently under the care of a physician? __ Y __ N
Has puberty begun? __ Y __ N
Has menstruation begun? (Girls) __ Y __ N
Please describe you child's current physical health: ___ Good ___ Fair ___ Poor
Please list all drugs that your child is currently taking: _____
_____
Please list all drugs / things that your child is allergic to : _____
_____

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

_Y _ N Abnormal bleeding
_ Y _ N Allergic to any drugs
_ Y _ N Allergic to Latex / Metals
_ Y _ N Allergic to Plastic
_ Y _ N Any Hospital Stays
_ Y _ N Any Operations
_ Y _ N Asthma
_ Y _ N Cancer
_ Y _ N Congenital Heart Defect
_ Y _ N Convulsions / Epilepsy
_ Y _ N Diabetes
_ Y _ N Handicaps / Disabilities
_ Y _ N Hearing Impairment
_ Y _ N Heart Murmur
_ Y _ N Hemophilia
_ Y _ N Hepatitis
_ Y _ N HIV+ ? AIDS
_ Y _ N Kidney / Liver Problems
_ Y _ N Rheumatic / Scarlet Fever
_ Y _ N Tuberculosis (TB)

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

Does / did 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 Mouth Breather
_ Y _ N Nail Biting
_ Y _ N Speech Problems
_ Y _ N Thumb / Finger Sucking
_ Y _ N Tongue Thrust

Neighbor or Relative not living with you.
Name _____ Phone (___)_____
Address _____
_____
City State Zip

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 any necessary dental services that my child may need .

_____
Signature of parent or guardian Date

Thank you for filling out this form completely.
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 the office, use the services of one or more credit reporting services. _____
Signature Date

If this office accepts insurance, I understand that I am responsible for payment of any services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____
Signature of parent or guardian Date

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.

_____
Office Use Only -- Office Use Only -- Office Use Only -- Office Use Only -- Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.
Doctor's Comments:_____Initials:_____ Date: _____
_____
_____