

# WELCOME

## Tell Us About Your Child

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Nickname: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last First MI

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ ☐ Male ☐ Female

E-mail Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
Apt / Condo #

City

State

Zip

## General Information

Who is accompanying the child today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? \_\_\_\_\_

Other siblings: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last Visit Date \_\_\_\_\_

Dentist's Phone #: (\_\_\_\_) \_\_\_\_\_

Relative or Friend not living with you:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip

## Parent's Information

Who is responsible for account? \_\_\_\_\_ Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Mother ☐ Step Father ☐ Step Mother ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's)

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) Ext: \_\_\_\_\_ Hm #: (\_\_\_\_)

Email: \_\_\_\_\_ Cell #: (\_\_\_\_)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City

State

Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City

State

Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

☐ **Mother** ☐ Father ☐ Step Mother ☐ Step Father ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's)

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) Ext: \_\_\_\_\_ Hm #: (\_\_\_\_)

Email: \_\_\_\_\_ Cell #: (\_\_\_\_)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City

State

Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City

State

Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

## Authorization

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 credit reporting services. If this office accepts insurance, 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

**Continued on Back**



## Dental & Medical History

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

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?

☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

Aside from items listed below, list all drugs/things your child is allergic to:

☐ Y ☐ N Latex

☐ Y ☐ N Nickel/Metals

☐ Y ☐ N Plastic

Has the child experienced the following medical problems?

☐ Y ☐ N Abnormal Bleeding

☐ Y ☐ N ADD/ADHD

☐ Y ☐ N AIDS/HIV+

☐ Y ☐ N Any Hospital Stays/Operations

☐ Y ☐ N Artificial Bones/Joints/Valves

☐ Y ☐ N Asperger Syndrome

☐ Y ☐ N Asthma

☐ Y ☐ N Autism

☐ Y ☐ N Cancer

☐ Y ☐ N Congenital Heart Defect

☐ Y ☐ N Convulsions

☐ Y ☐ N Diabetes

☐ Y ☐ N Epilepsy

☐ Y ☐ N Handicaps/Disabilities

☐ Y ☐ N Hearing Impairment

☐ Y ☐ N Heart Murmur

☐ Y ☐ N Hemophilia

☐ Y ☐ N Hepatitis

☐ Y ☐ N Kidney Problems

☐ Y ☐ N Liver Problems

☐ Y ☐ N Mitral Valve Prolapse

☐ Y ☐ N Prosthetics

☐ Y ☐ N Rheumatic Fever

☐ Y ☐ N Scarlet Fever

☐ Y ☐ N Sickle Cell Disease/Traits

☐ Y ☐ N Tuberculosis (TB)

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? \_\_\_\_\_

☐ Yes ☐ No

Are the child's immunizations current? \_\_\_\_\_

☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child has had:

Does/did the child experience any of the following?

☐ Y ☐ N Breast Fed

☐ Y ☐ N Clenching/Grinding Teeth

☐ Y ☐ N Lip Sucking/Biting

☐ Y ☐ N Mouth Breather

☐ Y ☐ N Nail Biting

☐ Y ☐ N Nursing Bottle Habits

☐ Y ☐ N Speech Problems

☐ Y ☐ N Thumb/Finger Sucking

☐ Y ☐ N Tongue Thrust

☐ Y ☐ N Used Pacifier

List any musical instruments played: \_\_\_\_\_

**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 I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that 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/orthodontic services my child may need.

Signature of Parent or Guardian

Date



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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist

Date

Dentist's Comments: \_\_\_\_\_

## Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. \_\_\_\_\_

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. \_\_\_\_\_

Parent/Guardian Signature

Date

Dentist Signature

Date

Parent/Guardian Signature

Date

Dentist Signature

Date