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WELCOME TO OUR OFFICE

SO THAT WE MIGHT BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING:

CHILD PATIENT INFORMATION

Patient's Name ______ Preferred Name ______ Sex ____

Home Address ______ City ______ Zip ______

Patient resides with ❑ Mother ❑ Father ❑ Both ❑ Other ______

Home Phone ______ Age ____ Birthdate ______ School ______ Grade ____

Email Address ______

Please describe your child's orthodontic problem in your own words______

Whom may we thank for referring you to our office?______

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

	FATHER	MOTHER
Name:		
Address (if different from above):		
Phone (if different from above):		
Social Security Number:		
Employer's Name:		
Business Address:		
Business Phone:		
Occupation:		
How long with this Employer:		
Person Responsible for Account:		
If other than parent:		

Name ______ Address ______ Phone ______

In case of emergency, please provide name, address and phone number of your nearest relative

______

NAME ADDRESS PHONE

INSURANCE INFORMATION

For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with claim forms from your insurance carrier on your first visit. Otherwise we will assume you are submitting all claims to your insurance carrier.

Name of Insured (Employee) ______ Date of Birth ______

Social Security Number ______

Name of Insurance Company______ Group # ______

Name of Insured (Employee) ______ Date of Birth ______

Social Security Number ______

Name of Insurance Company______ Group # ______

(over)

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All Information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: ______________________ Address ______________________ Phone ______________

Has your child experienced any health problems? ❑ No ❑ Yes Explain: ______________________

Any major change in your child's health recently? ❑ No ❑ Yes Explain: ______________________

Is your child currently under a physician's care? ❑ No ❑ Yes Explain: ______________________

Is your child currently taking medications? ❑ No ❑ Yes List: ______________________

Is your child allergic to any medications? ❑ No ❑ Yes List: ______________________

Has your child received a blood transfusion? ❑ No ❑ Yes Reason: ______________________

Have your child's tonsils or adenoids been removed? ❑ No ❑ Yes When: ______________________

Has your child been in a risk group for AIDS? ❑ No ❑ Yes Explain: ______________________

Is the patient pregnant at this time? ❑ No ❑ Yes

Please check if your child has had any of the following conditions:

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes
Heart Murmur	❑	❑	Hepatitis	❑	❑	Emotional Problems	❑	❑
Heart Surgery	❑	❑	Diabetes	❑	❑	Frequent Headaches	❑	❑
Rheumatic Fever	❑	❑	Kidney Disease	❑	❑	Nervous/Anxious	❑	❑
Endocrine Disorders	❑	❑	Liver Disease	❑	❑	Cancer	❑	❑
Prolonged Bleeding	❑	❑	Tuberculosis	❑	❑	Bone Disorders	❑	❑
Anemia	❑	❑	Bronchitis	❑	❑	Growth Disorders	❑	❑
Blood Disease	❑	❑	Asthma	❑	❑	Mouth Breather	❑	❑
Developmental Disorder	❑	❑	Epilepsy	❑	❑	Herpes (Fever Blisters)	❑	❑
Hives/Rash	❑	❑	Fainting	❑	❑	Tonsillitis	❑	❑
H.I.V. Positive	❑	❑						

Is there any other condition or problem that you think we should know about? ______________________

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty? ❑ No ❑ Yes

Girls – Has she started menstruation? ❑ No ❑ Yes When? ______________

Boys – Has his voice changed? ❑ No ❑ Yes When? ______________

Father's Height __________ Mother's Height __________ Adopted? ❑ No ❑ Yes

Names and Birthdates of patient's brothers and sisters: ______________________

Have either siblings or parents had orthodontic treatment? ❑ No ❑ Yes With whom: ______________

DENTAL HISTORY

Dentist's Name ______________________ Address ______________________ Phone ______________

Frequency of dental checkups: ❑ Twice a year ❑ Once a year ❑ Only if a problem exists ❑ Never Date of last visit ______________

Is there any unfinished care to be completed with your child's dentist? ❑ No ❑ Yes Explain: ______________

Is your child frightened about dental treatment? ❑ No ❑ Yes Explain: ______________

Has your child had an unpleasant experience in a dental office? ❑ No ❑ Yes Explain: ______________

Has your child had any face or dental injuries? ❑ No ❑ Yes Explain: ______________

Is there any history of thumb or finger sucking? ❑ No ❑ Yes Stopped? ______________

Does your child play a musical instrument? ❑ No ❑ Yes What instrument? ______________

Has your child consulted an orthodontist previously? ❑ No ❑ Yes With whom? ______________

Have teeth (either primary or permanent) been removed? ❑ No ❑ Yes

Has your child had any previous orthodontic treatment? ❑ No ❑ Yes With whom? ______________

Are you satisfied with prior treatment? ❑ No ❑ Yes Explain: ______________

Please check if there is a history of:

❑ Clenching teeth ❑ Muscular soreness around head & neck ❑ Jaw joint soreness ❑ Jaw point popping

❑ Grinding teeth ❑ Headaches (more than normal) ❑ Jaw point clicking ❑ Ringing in the ears

❑ Speech problems (if so, which sounds ______________) ❑ Mouthbreathing: Awake___ Asleep___

Is there any other information which may be helpful? ______________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR UPDATING ANY CHANGES OR ADDITIONS TO THIS INFORMATION IN THE FUTURE. I CONSENT TO A CREDIT REPORT.

______________________ Reviewed by: ______________

Parent's Signature Date