

WELCOME TO OUR OFFICE

So that we may become better acquainted, please complete **both** pages of this form.

CHILD PATIENT INFORMATION

Patient's Name _____ Nickname: _____ Sex: _____
Home Address: _____ City _____ Zip _____
Patient resides with: Mother Father Both Other _____ Length at Current Address: ___ yrs ___ months
Home phone: _____ Fax Number: _____ E-mail: _____
Age: _____ Birthdate: _____ School: _____ Grade: _____
Please describe your child's orthodontic problem in your words: _____
Patient Interests: _____
Whom may we thank for referring you to our office? _____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: Married Separated Divorced Widowed Other _____

FATHER

MOTHER

Name:	_____	_____
Address (if different):	_____	_____
Phone (if different):	_____	_____
Social Security #:	_____	_____
Employer's Name:	_____	_____
Business Address:	_____	_____
Business Phone:	_____	_____
Occupation:	_____	_____
Length at present Employer:	_____	_____

Person responsible for account: _____

If Other than Parent:

Name: _____ Address: _____ Phone: _____

Emergency contact: _____ Relationship: _____

Phone number: _____ Address: _____

In order for our office to offer extended payment plans, we may request a credit report unless you specify otherwise.

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for all fees incurred. 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 insurance information at your first visit. Otherwise we will assume that you are submitting all claims to your insurance carrier.

Name of Insured (Employee): _____ Date of Birth _____

Name of Insurance Company: _____ Group # _____

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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 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 medication? No Yes List: _____
- Is your child allergic to any medications? No Yes List: _____
- Has your child received a blood transfusion? No Yes Reason: _____
- Has your child's tonsils or adenoids been removed? No Yes When: _____
- Has your child been tested positive for HIV/AIDS? No Yes Explain: _____
- Has your child ever taken diet medications? No Yes List: _____

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

- | | | | | | |
|----------------|--|------------------------|--|-------------------------|--|
| Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nervous/Anxious | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Endocrine Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Prolonged bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Liver Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Growth Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mouth Breather | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Bronchitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hives/Rashes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes(fever blisters) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Developmental Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tonsillitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | Emotional Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | | | Frequent Headaches | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Is there any other condition or problem we should know about? _____

Comments? _____

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? _____
- Height _____ Do you feel growth is completed?..... No Yes
- 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 problem exists Never

Date of last dental 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 Which one? _____
- 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 Muscular soreness around head & neck Jaw joint soreness Jaw joint popping
- Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears
- Speech problems (if so, which sounds: _____) Mouth breathing: Awake _____ Asleep _____
- Tongue thrust habit

Is there any other information that may be helpful? _____

Parent's Signature _____

Date _____

Reviewed By _____