

# WELCOME

TELL US ABOUT YOUR CHILD		
Today's Date: ___/___/___ Nickname: _____		
Child's Name: _____		
Last	First	MI
Child's Birthdate: ___/___/___ Age: ___ <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian		<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian	
Name: _____ Birthdate: ___/___/___		Name: _____ Birthdate: ___/___/___	
Address: (If different than Child's) _____		Address: (If different than Child's) _____	
_____		_____	
SS #: _____ DL #: _____		SS #: _____ DL #: _____	
Wk #: (____) _____ Ext: _____ Hm #: (____) _____		Wk #: (____) _____ Ext: _____ Hm #: (____) _____	
Email: _____ Cell/Other #: (____) _____		Email: _____ Cell/Other #: (____) _____	
Employer: _____ Occupation: _____		Employer: _____	
Employer's Address: _____		Employer's Address: _____	
_____		_____	
City	State	Zip	Zip
If you have Orthodontic Insurance Coverage for the Child, please fill out below:		If you have Orthodontic Insurance Coverage for the Child, please fill out below:	
Insurance Co. Name: _____		Insurance Co. Name: _____	
Insurance Address: _____		Insurance Address: _____	
_____		_____	
City	State	Zip	Zip
Insurance Phone: (____) _____		Insurance Phone: (____) _____	
Group # (Plan, Local, or Policy #): _____		Group # (Plan, Local, or Policy #): _____	

AUTHORIZATION	
<p>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.</p>	
_____	_____
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

No  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 (Rubber) Y N Nickel/Metals Y N Plastic (Acrylic)

Y N Penicillin Y N Aspirin

**Has the child experienced the following medical problems?**

- |                                    |                                |
|------------------------------------|--------------------------------|
| Y N Abnormal Bleeding              | Y N Hearing impairment         |
| Y N ADD/ADHD                       | Y N Heart Murmur               |
| Y N AIDS/HIV+                      | Y N Hemophilia                 |
| Y N Any Hospital Stays/Oper.       | Y N Hepatitis A, B or C        |
| Y N Snoring                        | Y N Kidney Problems            |
| Y N Artificial Bones/Joints/Values | Y N Chemotherapy               |
| Y N Asthma                         | Y N Radiation Therapy          |
| Y N Cancer                         | Y N Liver Problems             |
| Y N Congenital Heart Defect        | Y N Mitral Valve Prolapse      |
| Y N Convulsions                    | Y N Prosthetics                |
| Y N Diabetes                       | Y N Rheumatic Fever            |
| Y N Epilepsy (Seizures)            | Y N Scarlet Fever              |
| Y N Herpes (cold sores)            | Y N Sickle Cell Disease/Traits |
| Y N Handicaps/Disabilities         | Y N Tuberculosis (TB)          |

Has the child ever taken any diet pills such as Phen-Fen?  Yes  No

(Also known as Redux or Pondimin.) If so, when? \_\_\_\_\_

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 Nursing Bottle 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              | 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

**OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY**

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?  Yes  No

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

Has there been any change in your child's health status since their last visit?  Yes  No

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

\_\_\_\_\_  
 Parent/Guardian Signature      Date

\_\_\_\_\_  
 Dentist Signature      Date

\_\_\_\_\_  
 Parent/Guardian Signature      Date

\_\_\_\_\_  
 Dentist Signature      Date

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