

About Your Child

Today's Date: _____
Name: _____
Preferred Name: _____
Gender: **Male** **Female**
Child's Birthdate: _____ Age: _____
Special interests, hobbies, or sports: _____

Child's Home Address: _____

Child's Home Phone #: _____

Person Accompanying Child Today

Name: _____
Relation: _____
Do have legal custody of this child? **Y N**
Whom may we thank for sending you to see us? _____
List brother/sisters with age: _____

General Dentist: _____
Last dental visit: _____
Parental Marital Status (please circle one):
Single Married Widowed
Divorced Separated

Mother's Information

Name: _____ DOB: _____
Is she the: **Guardian Step Mother**
Work #: _____ Home #: _____
Employer: _____
SS#: _____ Email: _____

Father's Information

Name: _____ DOB: _____
Is he the: **Guardian Step Father**
Work #: _____ Home #: _____
Employer: _____
SS#: _____ Email: _____

Primary Orthodontic Insurance

Orthodontic Coverage (yes/no): _____
Insurance Company Name: _____
Address: _____

Phone #: _____
Policy or ID#: _____
Policy Owner's Name: _____
Relationship to patient: _____
Policy Owner Birthdate: _____
Policy Owner's Employer: _____

Secondary Orthodontic Insurance

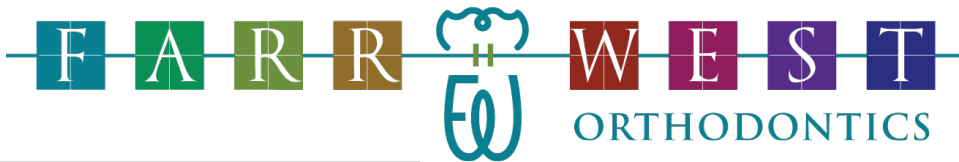
Orthodontic Coverage (yes/no): _____
Insurance Company Name: _____
Address: _____

Phone #: _____
Policy or ID#: _____
Policy Owner's Name: _____
Relationship to patient: _____
Policy Owner Birthdate: _____
Policy Owner's Employer: _____

Tertiary Orthodontic Insurance

Orthodontic Coverage (yes/no): _____
Insurance Company Name: _____
Address: _____

Phone #: _____
Policy or ID#: _____
Policy Owner's Name: _____
Relationship to patient: _____
Policy Owner Birthdate: _____
Policy Owner's Employer: _____



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

Has your child ever been evaluated or had orthodontic treatment before? **Yes No**

Have there been any injuries to the face, mouth, or chin? **Yes No**

Have adenoids or tonsils been removed? **Yes No**

Has your child been informed as to missing or extra permanent teeth? **Yes No**

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? **Yes No**

Does your child brush daily? **Yes No**

Floss his/her teeth daily? **Yes No**

Child's Physician: _____

Phone #: _____ Date of Last visit? _____

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

If yes, please explain: _____

Has puberty begun? **Yes No**

Females: Age at 1st menstruation? _____

Please describe your child's current physical health? **Good Fair Poor**

Does your child need to be pre-medicated before dental treatment? **Yes No**

Please list all medications that your child is taking: _____

Please list all medications that your child is allergic to? _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? PLEASE CIRCLE Y OR N

- | | |
|----------------------------------|----------------------------|
| Y N Abnormal bleeding/hemophilia | Y N Handicaps/Disabilities |
| Y N Allergies to any medications | Y N Hearing Impairment |
| Y N Allergic to latex | Y N Convulsions/Epilepsy |
| Y N Allergic to metals/plastics | Y N Tuberculosis (TB) |
| Y N Any hospital stays | Y N Hepatitis |
| Y N Any operations | Y N HIV+/AIDS |
| Y N Asthma | Y N Kidney/Liver problems |
| Y N Rheumatic/Scarlet fever | Y N Cancer |
| Y N Congenital heart defect | Y N Bed wetting |
| Y N Heart murmur | Y N Sleeping disorder |
| Y N Diabetes | Y N Snoring |

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

Does 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 Speech problems |
| Y N Mouth breathing | Y N Thumb/finger habit |
| Y N Nail biting | Y N Tongue thrust |

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 medical or insurance status. I authorize the dental staff to perform any necessary dental service with my informed consent that I may need during diagnosis and treatment. Also, I guarantee payment of all fees for treatment.

Assignment of Benefits: I hereby authorized payment to my attending Orthodontist. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that where appropriate credit bureau reports may be obtained.

Signature Date