FARR WEST ORTHODONTICS

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: _____

Dr. Michael R. Richards
1761 N 2000 W Farr West UT 84404, 801-731-4850, farrwestortho.com

FARR WEST ORTHODONTICS

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

Dr. Michael R. Richards
1761 N 2000 W Farr West UT 84404, 801-731-4850, farrwestortho.com