

WELCOME

To Your Orthodontist!

Tell Us About Your Child

Today's Date: ___/___/___ Nickname: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: ___ Male 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? Yes No

Whom may we Thank for referring you? _____

Other siblings/ages: _____

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

Father Step Father Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell #: (____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City State Zip

Insurance Phone: (____) _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Single Married Partnered Widowed Divorced Separated

Mother Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell #: (____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City State Zip

Insurance Phone: (____) _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Authorization

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.

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

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:

Latex Nickel/Metals Plastic

Has the child experienced the following medical problems?

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Any Hospital Stays/Operations | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sickle Cell Disease/Traits |
| <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> Breast Fed | <input type="checkbox"/> Nursing Bottle Habits |
| <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Thumb/Finger Sucking |
| <input type="checkbox"/> Mouth Breather | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> 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

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? Y N
 If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Has there been any change in your child's health status since their last visit? Y N
 If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Welcome to the Orthodontist

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt./Condo #

City State Zip

Single Married Partnered Divorced/Separated Widowed

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

Orthodontic Insurance

Primary

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Payment is due in full at the time of treatment
 unless prior arrangements have been approved.

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 payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

Continued on Back

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N HIV |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drugs/materials that you are allergic to: _____

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.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Patient Signature Date

Dentist Signature Date

Patient Signature Date

Dentist Signature Date

Dental History

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

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you still have wisdom teeth? Yes No

Have you ever had an injury to your: **Mouth** **Teeth** **Chin** (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? Yes No

If yes, please circle: **While Awake?** **While Asleep?**

Do you have any missing or extra permanent teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

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 that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services.

Signature _____

Date _____

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____
