

## WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete both sides of this form.

### CHILD PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Sex \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Patient resides with: ( ) Mother ( ) Father ( ) Both ( ) Other \_\_\_\_\_

Parent's email \_\_\_\_\_ Child's email \_\_\_\_\_

May we contact you by email? ( ) yes ( ) no May we contact you & leave messages on your cell phone? ( ) yes ( ) no

Referred by \_\_\_\_\_ Do you know a patient currently in our practice? Whom? \_\_\_\_\_

Describe the orthodontic problem in your own words \_\_\_\_\_

Patient's interests/hobbies \_\_\_\_\_

### PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

#### FATHER

#### MOTHER

Name \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employer's Name \_\_\_\_\_

Business Phone & Ext \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

### INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of 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 would like assistance, we ask that you provide us with a claim form or a copy of your insurance card from your insurance carrier on your first visit or as soon as possible. Otherwise, we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at the time of service or billing.

**Primary Insurance Carrier** \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber \_\_\_\_\_ SS# or ID# \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

**Secondary Insurance Carrier** \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber \_\_\_\_\_ SS# or ID# \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ 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 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 \_\_\_\_\_

Is your child allergic to latex or metals? ( ) 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 \_\_\_\_\_

Does your child use tobacco products? ( ) No ( ) Yes

Has your child ever taken biphosphonates (orally or IV) to treat cancer, bone disorders or osteoporosis? ( ) No ( ) Yes Explain? \_\_\_\_\_

Heart Murmur	( ) No ( ) Yes	Hepatitis	( ) No ( ) Yes	Emotional Problems	( ) No ( ) Yes
Heart Surgery	( ) No ( ) Yes	Diabetes	( ) No ( ) Yes	Frequent Headaches	( ) No ( ) Yes
Rheumatic Fever	( ) No ( ) Yes	Kidney Disease	( ) No ( ) Yes	Nervous/Anxious	( ) No ( ) Yes
Endocrine Disorders	( ) No ( ) Yes	Liver Disease	( ) No ( ) Yes	Cancer	( ) No ( ) Yes
Prolonged Bleeding	( ) No ( ) Yes	Tuberculosis	( ) No ( ) Yes	Bone Disorders	( ) No ( ) Yes
Anemia	( ) No ( ) Yes	Bronchitis	( ) No ( ) Yes	Growth Disorders	( ) No ( ) Yes
Blood Disease	( ) No ( ) Yes	Asthma	( ) No ( ) Yes	AIDS	( ) No ( ) Yes
Developmental Disorder	( ) No ( ) Yes	Epilepsy	( ) No ( ) Yes	Herpes-fever blisters	( ) No ( ) Yes
Hives/Rash	( ) No ( ) Yes	Fainting	( ) No ( ) Yes	Tonsillitis	( ) No ( ) Yes

Is there any other condition or problem that you think we should know about? \_\_\_\_\_

### 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 child 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 complete? ( ) No ( ) Yes

Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_ Is child adopted? ( ) No ( ) Yes

Names & birth dates of patient's brothers and sisters \_\_\_\_\_

Have other siblings or parents had orthodontic treatment? ( ) No ( ) Yes With whom? \_\_\_\_\_

### DENTAL HISTORY

Dentist's Name: \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Frequency of dental check ups: Twice a year ( ) Once a year ( ) Only if a problem exists ( ) Never ( )

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 facial or dental injuries? ( ) No ( ) Yes Explain \_\_\_\_\_

Does your child play a musical instrument? ( ) No ( ) Yes Which instrument \_\_\_\_\_

Does your child play sports? ( ) No ( ) Yes Which sport \_\_\_\_\_

Does your child wear a mouth guard while playing sports? ( ) No ( ) Yes

Have you consulted an orthodontist previously for your child? ( ) No ( ) Yes With whom \_\_\_\_\_

Have primary or permanent teeth been removed? ( ) No ( ) Yes Explain \_\_\_\_\_

Has your child had any previous orthodontic treatment? ( ) No ( ) Yes With whom \_\_\_\_\_

Is there a history of thumb or finger sucking? ( ) No ( ) Yes Stopped at what age? \_\_\_\_\_

Please check if there is a history of:

( ) clenching teeth	( ) muscular soreness around head & neck	( ) jaw joint soreness	( ) jaw joint popping/clicking
( ) grinding teeth	( ) headaches (more than normal)	( ) excessive snoring	( ) ringing in the ears
( ) speech problems; if so which sounds _____		( ) mouth breathing when awake	

Is there any other information that may be helpful? \_\_\_\_\_

**I, the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice.**

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by: \_\_\_\_\_

FOR DOCTOR'S USE ONLY. PREMEDICATE FOR BANDING / DEBANDING ( ) YES ( ) NO