Welcome to the Orthodontist

1 ABOUT YOUR CHILD

His / Her Name: ____

Nickname: ___________________ ☐ MALE ☐ FEMALE

Birthdate: ____/ ____/ ____ SSN: _________________

Home Address: ____
APT/CONDO#

____
CITY STATE ZIP

Cell #: (_____) _____-______ Hm #: (_____) _____-______

Special interest, sport, or hobbies: __________________________

____

____

2 ACCOMPANYING CHILD?

Name: _______________________ Relation: ___________________

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers/sisters with age: ______________________________

____

General Dentist: ____

Last Visit Date: ____

Parent's Marital Status: ☐ Single ☐Widowed

☐ Married ☐ Divorced ☐ Separated

3 PARENT INFORMATION

☐ **Mother's Information:** ☐ Step Mother ☐ Guardian

Name: ____________________________ Birthdate: ____________

Email Address: ____

Cell #: (_____) _____-______ Hm #: (_____) _____-______

Employer: ______________________ Wk #: (_____) _____-______

SSN: ___________________ DL #: ____________________

☐ **Father's Information:** ☐ Step Father ☐ Guardian

Name: ____________________________ Birthdate: ____________

Email Address: ____

Cell #: (_____) _____-______ Hm #: (_____) _____-______

Employer: ______________________ Wk #: (_____) _____-______

SSN: ___________________ DL #: ____________________

4 ORTHODONTIC INSURANCE

Orthodontic Coverage? Y N

Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

____
City State Zip

Insurance Co. Phone #: (______) ______-_______

Group #: __________________ ID #: ______________________

Policy owner's (PO) name: __________________________________

Relationship to child: ______________________________________

PO's SSN: __________________ PO's Birthdate: _______________

Employer: ____

Employer's Address: ____

Secondary Dental Insurance | Orthodontic Coverage? Y N

Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

____
City State Zip

Group #: __________________ ID #: ______________________

Policy owner's (PO) name: __________________________________

Relationship to child: ______________________________________

PO's SSN: __________________ PO's Birthdate: _______________

Employer: ____

Employer's Address: ____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: __________________ Relation: ________________

Cell #:(_____) _____-______ Hm #: (_____) _____-______

5 RESPONSIBLE FOR ACCOUNT

Name: ______________________ Relation: ___________________

Billing Address: ____
APT/CONDO#

____
CITY STATE ZIP

Cell #: (_____) _____-______ Hm #: (_____) _____-______

Wk #: (_____) _____-______ Ext: ________ SSN: ______________

Who is responsible for making appointments?

Name: ______________________ Relation: ___________________

CONTINUED ON BACK

6 DENTAL/MEDICAL HISTORY

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

____

____

Has your child seen an orthodontist before? Y N   Dentist? Y N

Treatment done: _______________________________

Previous orthodontist: ___________________________

Date of last visit? Dentist: __________ Orthodontist: __________

Are there any dental problems that you are aware of at present?

Y N   If yes, please explain: _______________________

____

Does your child brush his/her teeth daily?   Y N

Y N Still have wisdom teeth Y N Missing or extra permanent teeth

Please rate your child's oral health: ☐ Good ☐ Fair ☐ Poor

Date of child's first period (if applicable): ___________

Is your child currently under the care of a physician?   Y N

Child's physician: _____________________________

Phone #: (_____) _____ - ______ Date of last visit: ___________

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor\

Is your child allergic to any drugs or other thing?   Y N

If yes, please list: _____________________________

Is your child taking any prescription drugs?   Y N

If yes, please list: _____________________________

Does your child require antibiotics before dental treatment?

Y N

7 MEDICAL PROBLEMS

Has your child ever had any of the following medical conditions or problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joint /Valves
Y N Arthritis
Y N Severe/Frequent Headaches
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Hemophilia/Abnormal Bleeding
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Diabetes
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Ever Hospitalized
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Treatment
Y N Rheumatic/Scarlet Fever
Y N Asthma
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any additional medical problems you child has: ________

____

____

8 HABITS/PROBLEMS

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Sensitive Teeth
Y N Difficulty Opening Mouth
Y N Tonsils/Adenoids Removed
Y N Play Musical Instrument
Y N TMJ/TMD
Y N Nursing Bottle
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Joint Noises
Y N Bite Uncomfortable
Y N Jaw Stuck/Locked/Out
Y N Injury to Head/Mouth

Explain injury: ______________________________

Was your child breast fed? Y N

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 child's medical status. I authorize the dental staff to perform any necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. all insurance benefits otherwise payable to me. 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 payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/Guardian Signature: ______________________________   Date: ____________________

Medical History Update

Date: __________ Comments: ____________________ Parent/Guardian Signature: ____________________

Date: __________ Comments: ____________________ Parent/Guardian Signature: ____________________

Date: __________ Comments: ____________________ Parent/Guardian Signature: ____________________

Date: __________ Comments: ____________________ Parent/Guardian Signature: ____________________

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: ______ Date: _____