Welcome

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In an effort to provide the best service possible we ask you to fill out this form completely. Thank you for your cooperation.

Date: ________________ **Latex Allergy:** O Yes O No

Patient Information - Child or Teen

Patient's Name ______________ (First) ______________ (Middle) ______________ (Last) Age ________ Birth Date ____________

Nickname ____________ O Male O Female School ____________ Patient's Home Phone ____________

Patient's Home Address ______________ (Street) City, State ______________ ZIP ________

Family Email ______________ How did you hear about us? ______________

Dentist's Name ______________ Date of last visit ______________

Have we treated another member of your immediate family? O Yes O No If YES, Name ________ (First) ________ (Middle) ________ (Last)

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

Has your child visited an orthodontist before? O Yes O No If YES, for what reason? ______________

Patient's attitude toward treatment? ______________

Parents Information

Marital Status O Single O Married O Widowed O Divorced O Separated O Domestic Partner

Father

O Father O Step Father O Guardian Name ______________

Address (if different than child's) ______________

Home # ____________ Work # ____________ Cell # ____________

Employer ____________ Employer's Address ____________ Employer's# ____________

If the child has DENTAL insurance coverage by the party listed above, please fill out.

Insurance Company Name ____________ Group or Plan # ____________

Insurance Company Phone ____________ Insurance Company Address ____________

Policy Holder's Name ____________ Policy Holder's Birth Date ____________ SS# ____________

Mother

O Mother O Step Mother O Guardian Name ______________

Address (if different than child's) ______________

Home # ____________ Work # ____________ Cell # ____________

Employer ____________ Employer's Address ____________ Employer's# ____________

If the child has DENTAL insurance coverage by the party listed above, please fill out.

Insurance Company Name ____________ Group or Plan # ____________

Insurance Company Phone ____________ Insurance Company Address ____________

Policy Holder's Name ____________ Policy Holder's Birth Date ____________ SS# ____________

Dental History

Why are you interested in orthodontic treatment for your child? ____________________

____

____

Date of last dental care ____________________

How often does your child brush? ____________ Floss? ____________

Has your child ever experienced a mouth or chin injury? ☐ Y ☐ N

Does your child have any habits / problems affecting the mouth or teeth? ____________

Which musical instruments does your child play? ____________________

Does your child usually breathe through their mouth while awake? ☐ Y ☐ N Or asleep? ☐ Y ☐ N

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your child's dental health or previous treatment ____________

Medical History

Child's Physician ____________________ Phone ____________

Date of last visit ____________ Has your child had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe ____________________

____

Is your child currently under physician care? ☐ Y ☐ N If yes, describe ____________

Has your child ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates ____________

Have the child's adenoids or tonsils been removed? ☐ Y ☐ N

Check if your child has had any of the following:

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Blood Disease
- ☐ Cancer
- ☐ Convulsions / Epilepsy
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches
- ☐ Heart Problems Describe ____________
- ☐ Hearing Impairment
- ☐ Hemophilia / Abnormal bleeding
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Respiratory disease
- ☐ Rheumatic / Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Thyroid disease or malfunction
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other ____________
- ☐ Other ____________

List medications your child is taking, if any:

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____

List drug allergies, if any:

____

____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine approprate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the authorized insurance company to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date ____________

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