

**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

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

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

Patient Interests \_\_\_\_\_

**PARENTS AND ACCOUNT INFORMATION**

Parent's Marital Status  Married  Separated  Divorced  Widowed

**FATHER**

**MOTHER**

Name	_____	_____
Address (if different from above)	_____	_____
(city, state, zip code)	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Employer's Name	_____	_____
Business Phone (extension or department)	_____	_____
Occupation	_____	_____

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 wish assistance, we ask that you provide us with a claim form 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 time of service or billing.

**Primary**

Name of insured (Employee) \_\_\_\_\_ SS# or ID# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Employer \_\_\_\_\_

**Secondary**

Name of insured (Employee) \_\_\_\_\_ SS# or ID# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Employer \_\_\_\_\_

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 medications?  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: \_\_\_\_\_

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

Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Emotional Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervous/Anxious	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocrine Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Prolonged Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bone Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Growth Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blood Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes
Developmental Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Herpes(fever blisters)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hives/Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tonsillitis	<input type="checkbox"/> No <input type="checkbox"/> 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 son or daughter 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 completed?  No  Yes
- Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_ Adopted?  No  Yes
- Names & Birth dates of patient's brothers and sisters \_\_\_\_\_
- Have either siblings or parents had orthodontic treatment?  No  Yes With whom? \_\_\_\_\_

**DENTAL HISTORY**

Dentist's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

Frequency of dental checkups: Twice a year  Once a year  Only if a problem exist  Never  Date of last visit \_\_\_\_\_

- 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 face or dental injuries?  No  Yes Explain: \_\_\_\_\_
- Does your child play any musical instruments?  No  Yes What instrument? \_\_\_\_\_
- Does your child play sports?  No  Yes Which sports? \_\_\_\_\_
- Does your child wear a mouth guard while playing sports?  No  Yes
- Has your child consulted an orthodontist previously?  No  Yes Whom? \_\_\_\_\_
- Have teeth (either primary or permanent) been removed?  No  Yes
- Has your child had any previous orthodontic treatment?  No  Yes With whom? \_\_\_\_\_
- Are you satisfied with prior treatment?  No  Yes Explain: \_\_\_\_\_
- Is there a history of thumb or finger sucking?  No  Yes Stopped? \_\_\_\_\_

- 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: 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**