



About Your Child

General Information

Today's Date: ___/___/___ Nickname: _____
Child's Name: _____
Last First Middle
 Child's Birthday: ___/___/___ 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

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 Information

Who is responsible for account? _____ Parent's Marital Status: ___ Single ___ Married ___ Partnered ___ Widowed ___ Divorced ___ Separated
 ___ Father ___ Step Father ___ Guardian
 ___ Mother ___ Step Mother ___ Guardian
 Name: _____ Birthday: ___/___/___ Name: _____ Birthday: ___/___/___
 Address: (If different from above) Home #: (____) _____ Address: (If different from above) Hm #: (____) _____

 SS #: _____ DL #: _____ SS #: _____ DL#: _____
 Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____ Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____
 Email Address: _____ Email Address: _____
 Employer: _____ Occupation: _____ Employer: _____ Occupation: _____
 Employer's Address: _____ Employer's Address: _____

 City State Zip City State Zip
 If you have Orthodontic Insurance Coverage for the child, please fill out below: If you have Orthodontic Insurance Coverage for the child, please fill out below:
 Insurance Co. Name: _____ Insurance Co. Name: _____
 Insurance Address: _____ Insurance Address: _____

 City State Zip City State Zip
 Insurance Phone: (____) _____ Insured's ID #: _____ Insurance Phone: (____) _____ Insured's ID #: _____
 Group # (Plan, Local, or Policy #): _____ 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 agencies. 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 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

Dental and 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 your child ever had any pain/tenderness in his/her jaw joint TMJ/TMD)?

Yes No

Does your 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 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:

Y N Latex Y N Nickel/Metals Y N Plastic

Has the child experienced the following medical problems?

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

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

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Dentist's Comments: _____

Signature of Parent or Guardian

Date

Medical History Update

Has there been any change in your child's health status since their last visit? Yes No

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? Yes No

If Yes, please explain: _____

Parent/Guardian Signature Date

Dentist Signature Date