Account# _____

C: _____ Family: _____

Welcome
to the Orthodontist

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your child

Todays Date: _____

Child's Name: _____
Last Mid. Init.

Birthday: _____ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: _____

Child's Home Address:

_____
City State Zip

Have we treated an immediate family member before? ☐ Yes ☐ No

Name: _____

Person responsible for account

Name: _____ Relation: _____

Billing address: _____

_____
City State Zip

Home # _____ Cell # _____

Employer: _____ Work # _____ Ext.

SS #: _____ DL #: _____

Who is accompanying your child today?

Name: _____ Relation: _____

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

Whom may we thank for referring you?: _____

List brothers / sisters with age: _____

_____

General Dentist:

Parents marital status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

☐ **Mothers Information** ☐ Stepmother ☐ Guardian

Name: _____ Birthday: _____

Home # _____ Cell # _____

Employer: _____ Work # _____ Ext. _____

How long at current job: _____ Job title: _____

SS #: _____ DL #: _____

☐ **Fathers Information** ☐ Stepfather ☐ Guardian

Name: _____ Birthday: _____

Home # Cell # _____

Employer: _____ Work # _____ Ext.

How long at current job: _____ Job title: _____

SS #: _____ DL #: _____

Primary Orthodontic Insurance

Orthodontic coverage: ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. address: _____

Insurance Co. phone #: _____

Group #: _____ Id. #: _____

Policy owners name: _____

Relationship to patient: _____

Policy owners birthday: _____

Policy owners employer: _____

Secondary Orthodontic Insurance

Orthodontic coverage: ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. address: _____

Insurance Co. phone #: _____

Group #: _____ Id. #: _____

Policy owners name: _____

Relationship to patient: _____

Policy owners birthday: _____

Policy owners employer: _____

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

_____

_____

Has your child ever taken Bisphosphonates? ☐ Yes ☐ No

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Has your child ever had any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Has your child had adenoids or tonsils removed? ☐ Yes ☐ No

Has your child ever been informed of 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

Does your child floss his/her teeth daily? ☐ Yes ☐ No

Childs physician: _____

Phone #: Date of last visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Please describe your childs current physical health. ☐ Good ☐ Fair ☐ Poor

Please list all the drugs that your child is currently taking: _____

_____

Please list all drugs/things that your child is allergic to: _____

_____

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

Y N	Abnormal bleeding	Y N	Convulsions/Epilepsy
Y N	ADD/ADHD	Y N	Diabetes
Y N	Allergies to any drugs	Y N	Handicaps/disabilities
Y N	Allergic to Latex	Y N	Hearing impairment
Y N	Allergic to metals	Y N	Heart murmur
Y N	Allergic to plastic	Y N	Hemophilia
Y N	Any hospital stays	Y N	Hepatitis
Y N	Any operations	Y N	HIV+/AIDS
Y N	Artificial bones/joints/valves	Y N	Kidney/liver problems
Y N	Asthma	Y N	Lupus
Y N	Cancer	Y N	Rheumatic/Scarlet fever
Y N	Congenital heart defect	Y N	Tuberculosis

Please discuss any medical problems that your child has had: _____

_____

_____

_____

Has your child ever experienced any of the following?

Y N	Clenching/grinding teeth	Y N	Nursing bottle habits
Y N	Lip sucking/biting	Y N	Speech problems
Y N	Mouth breather	Y N	Thumb/finger sucking
Y N	Nail biting	Y N	Tongue thrust

Relative or neighbor not living with you:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone # _____

The parent or guardian who accompanies the child is responsible for payment.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my childs medical status

I authorize the orthodontic staff to perform the necessary orthodontic services my child may need.

_____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of the potential patients and/or parents of the 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 services.

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 payment of the group insurance benefits directly to this office.

_____ _____

Signature of parent or guardian Date Signature of parent or guardian Date

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.