We strive to teach good oral care that will enable you	er child to have a beautiful smile that lasts a lifetime.
Tell Us About Your Child	Person Responsible For Account
Today's Date: Male Female	Name: Relation:
	Billing Address:
Child's Name: Nickname: SS#: M	
Child's Birthdate: Child's Age:	Previous Address:
School: Grade:	
Hobbies / Sports:	Hm #: (
Child's Home #: ()	
Child's Home Address:	Employer:
CITY STATE	CASE THE CONTRACTOR OF THE CASE OF THE CAS
	Who is responsible for making appointments?
E-Mail Address:	Name: Hm #: ()
	distance as being control on the con-
9	Neighbor or Relative not living with you.
Who Is Accompanying Your Child Today?	Name: Phone: ()
Name: Relation:	Address:
Do you have legal custody of this child?	CITY STATE OF
Whom may we Thank for referring you?	
List brothers / sisters with age:	5 Printers Incurrence
A. S.	Primary Insurance
General Dentist:	Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No
Last Visit Date:	Insurance Co. Name:
Parent's Marital Status: Single Widowed	Insurance Co. Address:
Married Divarced Separated	Insurance Co. Phone #: ()
	Group # (Plan, Local, ar Policy #):
	Policy Owner's Name:
Matheria Information - Startleton - Coming	Relationship to Patient:
Mother's Information: Step Mather Guardian	Palicy Owner's Birthdate:/ 55 #:
Name: Birthdote:	Policy Owner's Employer:
Wk #: () Ext: Hm #: ()	Secondary Insurance
Employer:	Dental Coverage? Yes No Ortha Coverage? Yes No
How Long of Current Job: Job Title:	Insurance Co. Name:
SS #: DL #:	Insurance Co. Address:
Father's Information: Step Father Goardion	Insurance Co. Phone #: ()
	Group # (Plan, Local, or Policy #):
Name: Birthdate:	Policy Owner's Name:
Wk.#: (Ext: Him.#: ()	Relationship to Patient:
Employer:	Policy Owner's Birthdate:/ SS #:

Policy Owner's Employer: __

CONTINUED ON BACK

How Long at Current Jobs _____ Job Titles ____

DL.#:

SS #:

What are the main concerns that you would like orthodonics to accomplish? Tos your child ever been evaluated or hod orthodonic treatment before? Who we here been evaluated or hod orthodonic treatment before? Who we here been only injuries to the fore, mouth, beeth or chin? Who we here been only injuries to the fore, mouth, beeth or chin? Who we deconids or tonsils been removed? What your child been informed of any missing or extra permanent beth? Who your child ever had any pain / tenderness in his / her jow joint (TMJ / TMD)? Wes No Does your child bush his / her reeth daily? Who your child ever had any pain / tenderness in his / her jow joint (TMJ / TMD)? Wes No Ploss his / her teeth daily? W		THE REAL PROPERTY.		
Has your child ever been evaluated or had arthodontic treatment before? Yes No Have there been any injuries to the face, mouth, beth or chin? Yes No Have adencids or tonsils been removed? Have adencids or tonsils been removed? Has your child been informed of any missing or extra permanent teath? Yes No Has your child breast permanent teath? Yes No Does your child brush his / her teeth daily? Yes No Has puberty begun? Please describe your child's current physical health: Sood Fair Poor Please list all drugs that your child is currently taking: Please list all drugs that your child is currently taking: Please list all drugs that your child is allergic to: In an any permanent of potential potients ond/or parents of potients 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. Signature of porent or guardian Date This office reserves the right to verify the credit stotus of potential potients and/or parents of potients 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.			Has your child ev	er had any of the
Hos your child ever been evaluated or had anthodontic treatment before? Yes No Howe there been any injuries to the foce, mouth, beeth or chin? Yes No List any musical instruments played: List an	arthodontics to accomplish? following medical pro			ical problems?
Has your child been information teeth? Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Obes your child brush his / her teeth daily? Obes your child brush his / her teeth daily? Notes No Child's Physician: Phone #: Date of Last Visit: Is your child ever token Phen-Fen? No Has puberry begun? Please discuss any medical problems that your child has had: Please describe your child's current physician? Please describe your child's current physical health: Good Fair Poor Please list all drugs that your child is allergic to: Please list all drugs/things that your child is allergic to: 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 child's medical status. I authorize the dental staff the perform the necessary dental services my child may need. My method of payment will be Signature of parent or guardian Date This office reserves the right to verify the credit status of potential patients and/or parents of potients 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. Signature of porent or guardian Date	treatment before? Have there been any injuries to the foce, mouth, teeth or chin? List ony musical instruments played:	Yes No	Y N ADD / ADHD Y N Allergies to any Drugs Y N Allergic to Latex / Metals Y N Allergic to Plastic Y N Any Hospital Stays Y N Any Operations	Y N Hondicaps / Disabilities Y N Hearing Impairment Y N Heart Murmur Y N Hemophilia Y N Hepatitis Y N HIV+ / AIDS
jaw joint (TMJ) / TMD)? Obes your child brush his / her teeth daily? Floss his / her teeth dai	Has your child been informed of any missing or extra permanent teeth?	Yes Na	Valves Y N Asthma Y N Cancer	Y N Liver Problems Y N Lupus Y N Rheumatic / Scarlet Fever
Child's Physician:Phone #: (jaw joint (TMJ / TMD)? Does your child brush his / her teeth daily?	Yes No	Y N Convulsions / Epilepsy	Y N Tuberculosis (TB)
Has puberty begun? Has puberty begun? (Girls) Has menstruation begun? (Girls) Has your child ever taken Phen-Fen? Yes	Child's Physician:			
Please describe your child's current physical health: Good Fair Poor	Has puberty begun?			1
Please describe your child's current physical health: Good Fair Poor Please list all drugs that your child is currently taking: Please list all drugs/things that your child is allergic to: V 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 Was your child breast fed? Y N Up Sucking / Biting Y N Tongue Thrust Was your child breast fed? Y N Up Sucking / Biting Y N Tongue Thrust Was your child breast fed? Y N Up Sucking / Biting Y N Tongue Thrust Was your child breast fed? Y N 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 child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. My method of payment will be Signature of parent or guardian Date 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 services. Signature of parent or guardian Date	· ·	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Signoture of parent or guardian Date This office reserves the right to verify the credit status of potential patients and/or parents of potients 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. Signature of porent or guardian Date	Please list all drugs that your child is currently taking: Please list all drugs/things that your child is allergic to: I understand that the information that I have confidence and it is my responsibility to information the necessary dental services my child me	ove given is corre	Y N Lip Sucking / Biting Y N Mouth Breather Y N Nail Biting Was your child be	Y N Speech Problems Y N Thumb / Finger Sucking Y N Tangue Thrust reast fed? Y N
ment fees and may, at the discretion of this office, use the services of one or more credit reporting services. Signature of parent or guardian Date		Signatu	ire of parent or guardian	Date
	ment fees and moy, at the discretion of this office,	, use		to extending credit for treat-
The Parent or Guardian who accompanies the shild is responsible for narment				UNAS
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the AD	The Parent or Guardia Our office is HIPAA Compliant and is committed to me	n who accompo eting or exceeding	unies the child is responsible for pay the standards of infection control mandate	ment. ed by OSHA, the CDC and the ADA.
		Y OFFICE	USE ONLY OFFICE USE ON	VLY OFFICE USE ONLY
verbally reviewed the medical / dental information above with the parent / guardian and patient named herein. octor's Comments: Initials:	Section 19 to 19 t	and the second s	No.	