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.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____
CHILD PREFERS TO BE CALLED

Child's Name: _____
LAST FIRST MI

E-mail Address: _____ SS#: _____

Birthdate: ___/___/___ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

2 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: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____) _____ Hm #:(____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

Parent: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____) _____ Hm #:(____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Previous Address: _____

_____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

Cell #: (____) _____ SS #: _____

Employer: _____ Wk # (___) _____ Ext: ____

Who is responsible for making appointments?

Name: _____

Wk # (____) _____ Ext: ____ Hm #: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

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

_____

Has your child ever been prescribed Fosamax or any other bisphosphonate? ☐ Yes ☐ No If yes, when? _____

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child 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

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

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: _____

_____

Y N Latex Y N Metals/Nickel Y N Plastics

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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	Covid-19
Y N	Allergies to any Drugs	Y N	Diabetes
Y N	Allergic to Latex / Metals	Y N	Handicaps / Disabilities
Y N	Allergic to Plastic	Y N	Hearing Impairment
Y N	Any Hospital Stays	Y N	Heart Murmur
Y N	Any Operations	Y N	Hemophilia
Y N	Artificial Bones / Joints / Valves	Y N	Hepatitis
Y N	Asperger Syndrome	Y N	HIV+ / AIDS
Y N	Asthma	Y N	Kidney / Liver Problems
Y N	Autism	Y N	Lupus
Y N	Cancer	Y N	Rheumatic / Scarlet Fever
Y N	Congenital Heart Defect	Y N	Tuberculosis (TB)

Has your child received Covid-19 vaccinations? ☐ Yes ☐ No

Type? _____ Date(s)? _____

Please discuss any medical problems that your child has had:

_____

_____

_____

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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

Neighbor or relative not living with you in case of emergency.

Name _____ **Phone** (___) _____

Address _____

_____

CITY STATE ZIP

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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.

_____ _____

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

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. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

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.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____