Welcome To Our Office

Please complete BOTH sides of this form.

Child Patient Information

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ City: _____ Zip: _____

Patient resides with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Home Phone: _____ Age: _____ Birthdate: _____ School: _____ Grade: _____

Please describe your child's orthodontic problem in your own words: _____

Patient's interests: _____

Whom may we thank for referring you to our office? _____

Parent and Account Information

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

	FATHER	MOTHER
Name:		
Address:		
City, State, Zip:		
Phone:		
Birthdate:		
Social Security #:		
Occupation:		
Employer:		
Business Phone:		

Person responsible for account: _____

If other than parent:

Name: _____ Address: _____ Phone: _____

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 payment of all fees incurred. For you convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, please let us know and we will provide you with the necessary orthodontic insurance forms. Otherwise, we will assume you are submitting all claims to your insurance carrier.

Name of insured (Employee): _____ Date of Birth: _____

Name of insurance company: _____ Group #: _____

Name of insured (Employee): _____ Date of Birth: _____

Name of insurance company: _____ Group #: _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.

Medical History

Physician's Name: _____ Address: _____ 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	Explain: _____
Is your child allergic to any medications?	☐ No	☐ Yes	Explain: _____
Has your child received a blood transfusion?	☐ No	☐ Yes	Explain: _____
Have your child's tonsils or adenoids been removed?	☐ No	☐ Yes	Explain: _____
Has your child been in a risk group for AIDS?	☐ No	☐ Yes	Explain: _____

Please check if your child has any of the following conditions:

Heart Murmur	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Emotional Problems	☐ No	☐ Yes
Heart Surgery	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Frequent Headaches	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Nervous/Anxious	☐ No	☐ Yes
Endocrine Disorders	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Prolonged Bleeding	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Bone Disorders	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Growth Disorders	☐ No	☐ Yes
Blood Disease	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Mouth Breather	☐ No	☐ Yes
Developmental Disorder	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Herpes (Fever Blisters)	☐ No	☐ Yes
Hives/Rash	☐ No	☐ Yes	Fainting	☐ No	☐ Yes	Tonsillitis	☐ No	☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

_____

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 and birthdates of patient's siblings: _____

Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes With whom: _____

Dental History

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of dental checks: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ 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 facial or dental injuries?	☐ No	☐ Yes	Explain: _____
Is there any history of thumb or finger sucking?	☐ No	☐ Yes	Stopped? _____
Does your child play a musical instrument?	☐ No	☐ Yes	What instrument? _____
Has your child consulted an orthodontist previously?	☐ No	☐ Yes	With whom? _____
Have teeth (either primary or permanent) been removed?			
Has your child had any previous orthodontic treatment?	☐ No	☐ Yes	With whom? _____
Are you satisfied with prior treatment?	☐ No	☐ Yes	Explain: _____

Please check if there is any history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking

☐ Ringing in the ears ☐ Jaw joint soreness

☐ Speech problems (which sounds _____) ☐ Mouth breathing: Awake_____ Asleep_____

Is there any other information that may be helpful? _____

_____

Parent's Signature Date Reviewed by: