

# WELCOME TO OUR Orthodontic Office

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'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

**4**

## Person Responsible For Account

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 \_\_\_\_\_ City State Zip  
 Previous Address: \_\_\_\_\_  
 \_\_\_\_\_ City State Zip  
 Hm#: (\_\_\_\_\_) \_\_\_\_\_ DL#: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Wk #: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_  
**Who is responsible for making appointments?**  
 Name: \_\_\_\_\_  
 Wk # (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ HM #: \_\_\_\_\_

**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: \_\_\_\_\_  
 Single  Partnered  Divorced  
 Parent's Marital Status:  Married  Separated  Widowed

**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: \_\_\_\_\_

**3**

## Mother's Information Step Mother Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
 Wk #: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 How long at Current Job: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 SS# \_\_\_\_\_ DL# \_\_\_\_\_

## Father's Information Step Father Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
 Wk #: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 How long at Current Job: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 SS# \_\_\_\_\_ DL# \_\_\_\_\_

## 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**

**6** What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has your child ever taken Phen-Fen?  Yes  No  
 (Also known as Redux or Pandimin) 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 you 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 you child is allergic to: \_\_\_\_\_

Y N Latex      Y N Metals/Nickel      Y N Plastics

**7 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 / Metals         | Y N Hearing Impairment        |
| Y N Allergic to Plastic                | Y N Heart Murmur              |
| Y N Any Hospital Stays                 | Y N Hemophilia                |
| Y N Any Operations                     | Y N Hepatitis                 |
| Y N Artificial Bones / Joints / Valves | Y N HIV+ / AIDS               |
| Y N Asthma                             | Y N Kidney / Liver Problems   |
| Y N Cancer                             | Y N Lupus                     |
| Y N Congenital Heart Defect            | Y N Rheumatic / Scarlet Fever |
|  | Y N Tuberculosis (TB)         |

Please discuss any medical problems that your child has had:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8 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:  
 Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 CITY STATE ZIP

**9** I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 any necessary dental services that 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.

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.

\_\_\_\_\_  
 Signature of parent or guardian Date

\_\_\_\_\_  
 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**

I verbally reviewed the medical / dental information above with the parent / guardian named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_  
 Doctor's Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_