Welcome to

Axelrode
ORTHODONTICS
MORAGA, CALIFORNIA

Dr. Eric L. Axelrode, D.D.S., M.S.D.
Dr. Mark G. Axelrode, D.D.S., M.S.

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: _____ ☐ Male ☐ Female

Child's Name: _____

Nickname: _____ Child's Age: _____

Child's Birthdate: ___/___/___ Teacher: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home#: (____) _____

Child's Home Address: _____

_____
APT/CONDO#

Child lives with? ☐ Mom ☐ Dad ☐ Both

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 I sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

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

3 Mothers Information ☐ Step Mother ☐ Guardian

Name: _____

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

Wk #: (____)_____ Email: _____

Employer: _____

How Long at Current Job: __ Job Title: _____

Fathers Information ☐ Step Father ☐ Guardian

Name: _____

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

Wk #: (____)_____ Email: _____

Employer: _____

How Long at Current Job: __ Job Title: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address _____

_____

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

Wk #: (____)_____ Email: _____

Employer: _____

Who is Responsible for Making Appointments?

Name: _____

Best daytime contact number (____) _____

5 Primary Insurance Information

Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone #: (_____) _____

I.D. Number _____

Group Number _____

Policy Owners Name: _____

Relationship to Patient: _____

Policy Owners Birthdate: ___/___/___ SS # _____

Policy Owners Employer: _____

Secondary Insurance Information

Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone #: (_____) _____

I.D. Number _____

Group Number _____

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

Policy Owners Name: _____

Relationship to Patient: _____

Policy Owners Birthdate: ___/___/___ SS # _____

Policy Owners Employer: _____

Orthodontics for Adults and Children

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

_____

_____

_____

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 I tenderness in his/her jaw joint (TMJ I TMD)? ☐ Yes ☐ No

Does your child brush 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 that your child is allergic to: _____

_____

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

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies	Y	N	Handicaps I Disabilities
Y	N	Allergic to Latex I 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	Asthma	Y	N	HIV+ I AIDS
Y	N	Cancer	Y	N	Kidney I Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic I Scarlet Fever
Y	N	Convulsions I Epilepsy	Y	N	Tuberculosis

Please discuss any medical problems that your child has had:

_____

_____

_____

8 Does I did your child have any of following habits?

Y	N	Clenching I Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking I Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb I Finger Sucking
Y	N	Nail Biting	Y	N	Tongue T hrust

9 Neighbor or Relative not living with you

Name: _____ Phone#: (____)_____

Address: _____

_____

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 medical status.

I hereby authorize payment to my attending Orthodontist. I understand that am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDS and the ADA.

OFFICE USE ONLY

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

Doctors Comments:

_____ initials:_____ Date:_____

_____ initials:_____ Date:_____

_____