



# WELCOME TO OUR ORTHODONTIC OFFICE

We would like to welcome you and your child to our office. Our goal is to make your 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.

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### TELL US ABOUT YOUR CHILD

Child's Name: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### INFORMATION BELOW MUST BE FILLED OUT COMPLETELY

#### MOTHER'S INFORMATION Step-Mother Guardian

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

#### FATHER'S INFORMATION Step-Father Guardian

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

#### PRIMARY ORTHODONTIC INSURANCE

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group / Plan #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

#### SECONDARY ORTHODONTIC INSURANCE

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group / Plan #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?**

Parent: \_\_\_\_\_

Child: \_\_\_\_\_

Dentist: \_\_\_\_\_

Has your child ever been evaluated for or had orthodontic treatment before?  Yes  No

Have there been any injuries to the face, mouth, teeth or chin?  Yes  No

Please explain: \_\_\_\_\_

Have adenoids or tonsils been removed?  Yes  No

Has your child been informed of any missing or extra permanent teeth?  Yes  No

Which ones? \_\_\_\_\_

**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

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:

\_\_\_\_\_

**HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?**

- |                               |                               |
|-------------------------------|-------------------------------|
| Y N Abnormal Bleeding         | Y N Diabetes                  |
| Y N Allergies to any Drugs    | Y N Handicaps / Disabilities  |
| Y N Allergy to Latex / Metals | Y N Hearing Impairment        |
| Y N Allergy 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+ / AIDS               |
| Y N Cancer                    | Y N Kidney / Liver Problems   |
| Y N Congenital Heart Defect   | Y N Rheumatic / Scarlet Fever |
| Y N Convulsions / Epilepsy    | Y N Tuberculosis (TB)         |

Please discuss any medical problems that your child has had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?**

- |                                |                            |
|--------------------------------|----------------------------|
| 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

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

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

The Parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**OFFICE USE ONLY**

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

Doctor's Comments: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_