KUBO ORTHODONTIC GROUP
A DENTAL CORPORATION

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.

TELL US ABOUT YOUR CHILD

DATE: ___/___/___

Child's Name _____ ☐ Male ☐ Female

Home Address _____ City _____ Zip _____

Home Phone # _____ Age of Child _____ Child's Date of Birth ___/___/___

School _____ Grade _____

Hobbies/Sports _____

General Dentist _____ Date of Last Visit ___/___/___

Are there other Siblings ? ☐ Yes ☐ No Names/DOB _____

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 _____ Occupation _____

Social Security #___/___/___ Driver's License # _____ Email _____

Would you like to receive appointment reminders? ☐ Yes ☐ No If Yes, please circle: PHONE EMAIL

FATHER'S INFORMATION ☐ Step-Father ☐ Guardian

Name _____ Date of Birth ___/___/___

Home Phone # _____ Work Phone _____ Cell Phone # _____

Employer Name _____ Occupation _____

Social Security #___/___/___ Driver's License # _____ Email _____

ORTHODONTIC INSURANCE

Policy Holder's Name _____

Date of Birth ___/___/___ **ID# (mandatory for insurance billing)** ___/___/___

Employer Name _____

Name of Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip _____ Telephone # _____

Group / Plan # _____

Relationship to Patient _____

SECONDARY ORTHODONTIC INSURANCE

Policy Holder's Name _____

Date of Birth ___/___/___ **ID# (mandatory for insurance billing)** ___/___/___

Employer Name _____

Name of Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip _____ Telephone # _____

Group / Plan # _____

Relationship to Patient _____

Continued on back

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:_____

_____

_____

_____