WELCOME TO OUR OFFICE -

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So that we might become better acquainted, please complete both sides of this form.

CHILD PATIENT INFORMATION

Patient's Name _____ Preferred Name_____ Sex_____

Mailing Address_____City _____ Zip_____

Home Phone_____ Age _____ Birth date_____ School_____ Grade_____

Parent's email address_____

Patient resides with: [ ] Mother [ ] Father [ ] Both [ ] Other_____

Referred by _____Do you know a patient currently in our practice? Whom _____

Describe the orthodontic problem in your own words _____

Patient Interests_____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

	FATHER	MOTHER
Name	_____	_____
Address (if different from above) (city, state, zip code)	_____	_____
	_____	_____
Phone (if different from above)	_____	_____
Employer's Name	_____	_____
Business Phone (extension or department)	_____	_____
Occupation	_____	_____

Person Responsible for Account_____

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 the account is responsible for payment of all fees incurred. For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with a claim form from your insurance carrier on your first visit or as soon as possible. Otherwise we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at time of service or billing.

Primary
Name of Insured (Employee) _____ ID#_____ DOB_____

Insurance Co._____Group # _____Ins. Phone # _____

Employer_____ Ins. Claims Address: _____

Secondary
Name of Insured (Employee) _____ ID#_____ DOB_____

Insurance Co._____Group # _____Ins. Phone # _____

Employer_____ Ins. Claims Address: _____

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

MEDICAL HISTORY

Physician's Name_____ 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	List:_____
Is your child allergic to any medications?	[ ] No	[ ] Yes	List:_____
Is your child allergic to latex or metals?	[ ] No	[ ] Yes	List:_____
Has your child received a blood transfusion?	[ ] No	[ ] Yes	Reason:_____
Has your child's tonsils or adenoids been removed?	[ ] No	[ ] Yes	When:_____

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	AIDS	[ ] 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?_____

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 & Birth dates of patient's brothers and sisters_____

Have either siblings or parents had orthodontic treatment? [ ] No [ ] Yes With whom?_____

DENTAL HISTORY

Dentist's Name:_____

Address:_____ **City:**_____ **State**_____ **Phone**_____

Frequency of dental checkups: Twice a year [ ] Once a year [ ] Only if a problem exist [ ] 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 face or dental injuries?	[ ] No [ ] Yes	Explain:_____
Does your child play any musical instruments?	[ ] No [ ] Yes	What instrument?_____
Does your child play sports?	[ ] No [ ] Yes	Which sports?_____
Does your child wear a mouth guard while playing sports?	[ ] No [ ] Yes	
Has your child consulted an orthodontist previously?	[ ] No [ ] Yes	Whom?_____
Have teeth (either primary or permanent) been removed?	[ ] No [ ] Yes	
Has your child had any previous orthodontic treatment?	[ ] No [ ] Yes	With whom?_____
Are you satisfied with prior treatment?	[ ] No [ ] Yes	Explain:_____
Is there a history of thumb or finger sucking?	[ ] No [ ] Yes	Stopped?_____

Please check if there is a history of:

[ ] Clenching teeth [ ] Muscular soreness around head & neck [ ] Jaw joint soreness [ ] Jaw joint popping/clicking

[ ] Grinding teeth [ ] Headaches (more than normal) [ ] Excessive snoring [ ] Ringing in the ears

[ ] Speech problems (If so, which sounds_____) [ ] Mouth breathing: Awake_____ Asleep_____

Is there any other information that may be helpful?_____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice.

_____ _____ _____

Parent's signature **Date** **Reviewed by:**

FOR DOCTOR'S USE ONLY. PREMEDICATE FOR BANDING / DEBANDING [ ] YES [ ] NO