SPECIALISTS IN ORTHODONTICS

CREATING GENERATIONS OF BEAUTIFUL SMILES

CHILD

PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

TELL US ABOUT YOUR CHILD

Today's Date: _____ ❑ Male ❑ Female ❑ Neutral

Child's Name: _____

Nickname: _____ SS #: _____

Email Address: _____

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Home #: ( ) _____ Cell #: ( ) _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Pediatric/General Dentist _____

Last visit date: _____ Last cleaning date: _____

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 siblings with ages: _____

_____

Parent's Domestic Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑ Domestic Partners

PARENT'S INFORMATION

❑ Mother ❑ Father ❑ Step Parent ❑ Legal Guardian

Name: _____ Birthdate: _____

Work #: ( ) _____ Ext: _____ Other #: _____

Cell #: _____

Email: _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____

❑ Mother ❑ Father ❑ Step Parent ❑ Legal Guardian

Name: _____ Birthdate: _____

Work #: ( ) _____ Ext: _____ Other #: _____

Cell #: _____

Email: _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

City: _____ State: _____ Zip: _____

Previous Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ DL #: ( ) _____

Work #: ( ) _____ Ext: _____ SS #: _____

Cell #: ( ) _____

Email: _____

Employer: _____

Who is responsible for making appointments?

Name: _____ Relation: _____

Work #: ( ) _____ Ext: _____ Home #: ( ) _____

Neighbor or relative not living with you.

Name: _____ Best #: _____

Address: _____

City: _____ State: _____ Zip: _____

INSURANCE

PRIMARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, local or policy #): _____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____ SS#: _____

Policy Owner's Employer: _____

SECONDARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____ SS#: _____

Policy Owner's Employer: _____

MEDICAL HISTORY

Has your child had any of the following medical problems?

- ❑ Abnormal Bleeding
- ❑ ADHD/ADD
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones/Joints/Valves
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Epilepsy/Seizures/Fainting
- ❑ Fever Blisters/Herpes
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ HIV+/Aids
- ❑ Hospitalized for any reason
- ❑ Kidney Problems
- ❑ Obstructive Sleep Apnea
- ❑ Osteoporosis
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Rheumatic/Scarlet Fever
- ❑ Severe/Frequent Headaches
- ❑ Sinus Problems
- ❑ Sleep Disorders
- ❑ Snoring
- ❑ Tuberculosis (TB)

Please explain or list any serious medical problems and/or pertinent medical issues that your child has ever had: _____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Child's physician: _____

Phone #: _____ Date of last visit: _____

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current health? ❑ Good ❑ Fair ❑ Poor

Please list drugs/vitamins that your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____

DENTAL HISTORY

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

_____

Has your child ever been evaluated for orthodontic treatment? ❑ Yes ❑ No

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

List any musical instruments played: _____

Have your child's adenoids or tonsils been removed? ❑ Adenoids ❑ Tonsils ❑ No

Has your child been informed of any missing or extra permanent teeth?

❑ Missing ❑ Extra ❑ No

Has your child ever experienced pain/discomfort in the jaw joint (TMJ/TMD)?

❑ Yes ❑ No

Does your child brush his/her teeth daily? ❑ Yes ❑ No

How many times? _____

Does your child floss his/her teeth daily? ❑ Yes ❑ No

HABITS/SLEEP CONDITIONS

- ❑ Clenching/Grinding Teeth
- ❑ Lip Sucking/Biting
- ❑ Mouth Breather ❑ While awake ❑ While asleep?
- ❑ Nail Biting
- ❑ Speech Problems _____
- ❑ Thumb/Finger Sucking

Sleep Position: ❑ Side ❑ Back ❑ Stomach ❑ Varies

Is it easy for your child to fall asleep? ❑ Yes ❑ No

Does he/she feel rested upon awaking? ❑ Yes ❑ No

Does he/she stop breathing during sleep? ❑ Yes ❑ No

Did he/she ever have a sleep study (PSG)? ❑ Yes ❑ No Result was? _____

Average hours of sleep per night? _____

Does he/she wake often during the night? ❑ Yes ❑ No

Gasping during sleep? ❑ Yes ❑ No

PARENT AUTHORIZATION

_____

Signature **Date**

As 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.

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 orthodontic services that my child may need.

_____

Signature of parent or guardian **Date**

I _____ **Have received a copy of this office's** ***Notice of Privacy Practices.***

_____

Signature **Date**

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 patient named herein. Initials: _____ **Date:** _____

Doctor's Comments: _____