WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation. This is a secure form.

Patient Information - Child or Teen

Patient's Name _____ (First / Middle / Last) Age _____ Birth Date _____

Nickname (if preferred) _____ ☐ Male ☐ Female Patient's Home Phone _____

Patient's Home Address _____ (Street) City, State, ZIP _____

Who is filling in this form? Name _____ (First / Middle / Last)

Relationship _____ Do you have legal custody? ☐ YES ☐ NO

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? ☐ YES ☐ NO If YES, Name _____ (First / Middle / Last)

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

Has your child visited an orthodontist before? ☐ YES ☐ NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? ☐ YES ☐ NO

Parents Information

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Father

Father ☐ Step Father ☐ Guardian ☐ Name _____ (First / Middle / Last)

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Mother

Mother ☐ Step Mother ☐ Guardian ☐ Name _____ (First / Middle / Last)

Address (if different than child's) _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Address _____ Employer's # _____

If you have insurance coverage for the child, please fill out.

Insurance Company Name _____ Group or plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Dental and Medical History

Is the child currently under the care of a physician? ☐ YES ☐ NO If YES, for what reason? _____

Child's Physician _____ Phone # _____

History of major illness? ☐ YES ☐ NO If YES, please describe _____

Any sensitivities or allergies? ☐ YES ☐ NO If YES, please list _____

Currently taking any medications? ☐ YES ☐ NO If YES, please list _____ Amount/Dose _____

Has Puberty Begun? ☐ YES ☐ NO

Has menstruation (period) begun? ☐ YES ☐ NO ☐ NOT APPLICABLE

Has the child been treated for any of the following?

Arthritis ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Tuberculosis ☐

Asthma ☐ Cancer ☐ Epilepsy ☐ Nervous Disorder ☐

Does the child require antibiotics before dental treatment? ☐ YES ☐ NO If YES, explain _____

Have the adenoids or tonsils been removed? ☐ YES ☐ NO

Have you been informed of any missing or extra permanent teeth? ☐ YES ☐ NO

Have there been injuries to the child's face, mouth or chin? ☐ YES ☐ NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) ☐ YES ☐ NO

Does/Did the child have any of the following habits?

Grinding Teeth ☐ Finger/Thumb Sucking ☐ Prolonged Bottle/Pacifier ☐

Mouth Breather ☐ Speech Problems ☐ Chewing/Eating Problems ☐

Signature

I understand that the information that I have provided 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 hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____

Submit Your Information