Welcome

Confidential Patient Information

Date: _____

Patient's Name: _____
Last First Middle

Nickname: _____ Gender: ____ School: _____

Address: _____
Street City State Zip

Home Phone: (____)_____ Birthdate: ____/____/____ Social Security # _____

Hobbies / Sports / Interests: _____

General Dentist: _____ Date of last cleaning: _____

Please list all legal guardians: _____

Whom may we thank for referring you to our office? _____

Have we treated any other family members?_____

Confidential Responsible Party Information

Name: _____ Marital Status:_____
Last First Middle

Residence: _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address: _____
Street City State Zip

How long at this address: _____ Home phone: (____)_____Work Phone: (____)_____

Previous Address: (if less than 3 yrs.) _____
Street City State Zip

Email address: _____

Social Security # _____ Birthdate: ____/____/___ Relationship to Patient: _____

Employer: _____ No. Years Employed: _____ Occupation: _____

Spouse's Name: _____ Relationship to Patient: _____
Last First Middle

Employer: _____ No. Years Employed: _____ Occupation: _____

Social Security # _____ Birthdate: ____/____/____ Work Phone: (____)_____

Insurance Information

Policy Holder's Name:_____ Soc. Security # _____

Insurance Company: _____Group No. _____ Union Local No. _____

Insurance Co. Address: _____ Insurance Co. Phone: (____)_____

Policy Holder's Employer: _____

Do you have dual coverage? No ☐ Yes ☐ If yes: _____

Policy Holder's Name: _____ Soc. Security # _____

Insurance Company: _____Group No. _____Union Local No. _____

Insurance Co. Address: _____ Insurance Co. Phone: (____)_____

Policy Holder's Employer: _____

Continued on back

What would you like orthodontics to accomplish?

_____

Has your child ever taken Phen-Fen? ☐Y ☐N
(Redux or Pondimin) If yes, when? _____
Has your child ever been evaluated or had orthodontic treatment before? ☐Y ☐N
Have there been any injuries to the face, mouth, teeth, or chin? ☐Y ☐N
List any musical instruments played: _____
Have adenoids or tonsils been removed? ☐Y ☐N
Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N
Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐Y ☐N
Does your child brush his / her teeth daily? ☐Y ☐N
Does your child floss his / her teeth daily? ☐Y ☐N
Child's Physician : _____
Phone: (____)_____ Date of last visit: _____
Is your child under the care of a physician? ☐Y ☐N
Has puberty begun? ☐Y ☐N
Girls - has menstruation begun? ☐Y ☐N
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 / things that your child is allergic to:

_____

Latex Y ☐ Metals/Nickel Y ☐ Plastics Y ☐

Has your child ever had any of the following medical problems?

Y ☐ Abnormal Bleeding	Y ☐ Convulsions / Epilepsy
Y ☐ ADD / ADHD	Y ☐ Diabetes
Y ☐ Allergies to Any Drugs	Y ☐ Handicaps / Disabilities
Y ☐ Allergies to Latex / Metals	Y ☐ Hearing Impairment
Y ☐ Allergic to Plastic	Y ☐ Heart Murmur
Y ☐ Any Hospital Stays	Y ☐ Hemophilia
Y ☐ Any Operations	Y ☐ Hepatitis
Y ☐ Artificial Bones / Joints	Y ☐ HIV+ / AIDS
Y ☐ Artificial Valves	Y ☐ Kidney / Liver Problems
Y ☐ Asthma	Y ☐ Lupus
Y ☐ Cancer	Y ☐ Rheumatic / Scarlet Fever
Y ☐ Congenital Heart Defect	Y ☐ Tuberculosis (TB)

Please discuss any medical problems that your child has had :

_____

_____

Has your child ever experienced any of the following?

Y ☐ Clenching / Grinding Teeth	Y ☐ Nursing / Bottle Habits
Y ☐ Lip Sucking / Biting	Y ☐ Speech Problems
Y ☐ Mouth Breather	Y ☐ Thumb / Finger Sucking
Y ☐ Nail Biting	Y ☐ Tongue Thrust

Neighbor or Relative not living with you :

Name: _____ Phone: (____)_____

Address: _____
Street

_____
City State Zip

The information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my childs medical status. I authorize the dental staff to perform the necessary dental services that my child may need. This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____

SIGNATURE OF PARENT / GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and 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: _____

_____

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