

# WELCOME TO THE ORTHODONTIST



We would like to welcome you and your child to our office. Our goal is to make every child's 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.

## 1

### Tell Us About Your Child

Today's Date: \_\_\_\_\_ Nickname: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_  
LAST FIRST MI

E-mail Address: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ ☐ Male ☐ Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_

**Child's Home Address:** \_\_\_\_\_  
APT/CONDO #

CITY STATE ZIP

## 4

### Person Responsible For Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

Hm # (\_\_\_\_) \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_

### Who is responsible for making appointments?

Name: \_\_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ HM #: \_\_\_\_\_

## 2

### 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 brothers / sisters with age: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

## 3

### ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

### ☐ Father's Information: ☐ Step Father ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

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### Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CONTINUED ON BACK

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

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

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

List any musical instruments played: \_\_\_\_\_

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

**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 / things that your child is allergic to:** \_\_\_\_\_

☐ Latex

☐ Metals/Nickel

☐ Plastics

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

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

**Please discuss any medical problems that your child has had:**

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**Has your child ever experienced any of the following?**

<input type="checkbox"/> Clenching / Grinding Teeth	<input type="checkbox"/> Nursing Bottle Habits
<input type="checkbox"/> Lip Sucking / Biting	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Thumb / Finger Sucking
<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Tongue Thrust

**Neighbor or Relative not living with you.**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

CITY

STATE

ZIP

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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. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or 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 OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

**Doctor's Comments:**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_