Patient Information --- **CHILD**

**PLEASE PRINT**

DATE _____/_____/_____

- Patient _____
  FIRST MIDDLE LAST

M___ F____ Birthdate_____ Age_____

Phone (_____)_____-_____

Address _____

City_____ Zip _____

School _____ Grade _____

- Parent/Guardian Information

Parent Name (1) _____

DOB: _____ SSN:_____-_____-_____

Address _____

City_____ Zip_____

Phone (_____)_____-_____

**Email**: _____

Employed by _____ Position_____

Employer Address _____ Employer Phone (_____)_____-_____

Parent Name (2) _____ Phone (_____)_____-_____

DOB: _____ SSN:_____-_____-_____

Address _____ City _____ Zip _____

**Email:** _____ Employed by _____

Position _____ Employer Address _____

Employer Phone (_____)_____-_____

***DENTAL INSURANCE COVERAGE***

Employee Name _____

Employee D.O.B (xx/xx/xxxx)_____

Employee SSN _____-_____-_____

Employer Name _____

Employer Phone _____

Name of Insurance Co. _____

Insurance Co. Address

_____

_____

Insurance Co. Phone _____

Member ID Number _____

Policy or Group # _____

Employee Relationship to Patient_____

- Patient resides primarily with: ☐ Mother ☐ Father ☐ Both ☐ Other:_____

How did you hear about our practice? ☐ Ad ☐ Internet ☐ Family/Friend ☐ Physician ☐ Insurance ☐ Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to correct?

_____

Have you visited an orthodontist before? Yes No If yes, when? _____

Reason_____

Have we treated any other family members? Yes No

Name(s) _____

**Dental History:**

- General Dentist: _____Phone: (____)_____-_____ Last Visit:___/_____/_____

**Do you or have you ever had any of the following habits (circle all that apply)**

Clenching/Grinding Teeth  Lip Sucking/Biting  Mouth Breathing  Nail Biting

Thumb/Finger Sucking  Chewing/Eating Problem  Swallowing Problems  Smoking

- TONSILS ---  PRESENT  REMOVED  WHEN _____
- ADENIODS ---  PRESENT  REMOVED  WHEN _____

Have you ever experienced any missing or extra permanent teeth? _____

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? _____

Have you ever had an injury to (circle all that apply):  Teeth  Mouth  Chin

Do you have any speech problems?

If so, explain: _____

**Medical History:**

Are you currently being treated by a physician?  Yes  No

Reason:_____

Physician Name: _____ Phone:_____

Do you have any allergies/sensitivities to medications or latex?  Yes  No

If yes, please list_____

Do you need/use an EPI Pen?  Yes  No

Are you currently taking any prescription or over-the-counter medications?  Yes  No

If yes, please list _____

Have you had any serious illnesses or operations?  Yes  No

If yes, please describe_____

Have you ever had a blood transfusion?  Yes  No

If yes, give approximate dates:_____

**Circle if you have ever had any of the following:**

| | | | |
|---|---|---|---|
| Anemia | Asthma | Autism | Blood Disorder |
| Cough, Persistent | Diabetes | AIDS | Kidney or liver disease |
| Arthritis | Heart Trouble | T.B. | Rheumatic Fever |
| Hepatitis | Epilepsy | Brain Injury | Hearing Difficulties |

Other_____

## Authorization

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 of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____

Date: _____