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)

Abnormal Breathing   Nail Biting   Tongue Biting   Grinding Teeth   Smoking

Tongue Sucking   Lip Sucking/Biting   Speech Disorders   Tongue Thrusting   Mouth Breathing

Thumb/Finger Sucking   Tobacco Use (in any form)

- 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:

AIDS	Anemia	Arthritis	Artificial bones/joints/valves	Autism Sensory
Asthma	Blood Disorders	Brain Injury	Cancer / Cancer Medication	Diabetes
Dizziness/Fainting	Drug/Alcohol Abuse	Emphysema	Epilepsy	Frequently Tired
Glaucoma	Handicap or Disabilities		Hearing Impairment	Heart Attack
Heart Congenital Defect		Heart Murmur	Heart Surgery or Pacemaker	Heart Trouble
Hemophilia or Abnormal Bleeding		Hepatitis or Jaundice	Herpes	High Blood Pressure
Kidney Disease	Low Blood Pressure	Mitral Valve Prolapse	Periodontal Disease	Psychiatric Problem
Radiation Therapy	Respiratory Therapy	Respiratory Problems	Rheumatic Fever	Seizures
Shingles	Sickle Cell Disease	Stomach Troubles or Ulcers		Stroke
Thyroid Problem	Tuberculosis	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: ____