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: _____