

Pt. # _____

WELCOME TO OUR PRACTICE

MINOR

WELCOME TO OUR ORTHODONTIC PRACTICE

Please take this time to tell us about your child.

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ Male Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
Apt #

City State Zip

Person Responsible For Account

Name: _____ Relationship: _____

Billing Address: _____
City State Zip

Previous Address: _____
City State Zip

Hm # (____) _____ DL #: _____

Employer: _____

Wk: (____) _____ Ext. _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext. _____ Hm # (____) _____

Who is Accompanying your Child Today?

Name: _____ Relationship: _____

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: _____

Parental Marital Status: Single Widowed
 Married Divorced Separated

Primary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS # _____

Policy Owner's Employer: _____

Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____) _____ Ext. _____ Hm # (____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____) _____ Ext. _____ Hm # (____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

Secondary Orthodontist Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS # _____

Policy Owner's Employer: _____



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

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is your child currently under the care of a physician?
 Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) 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 to which your child is allergic: _____

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

Y N Abnormal Bleeding	Y N Diabetes
Y N Allergic to any Drugs	Y N Handicaps/Diabetes
Y N Allergic to Latex/Metals	Y N Hearing Impairment
Y N Allergic to Plastics	Y N Heart Murmur
Y N Any Hospital Stays	Y N Hemophilia
Y N Any Operations	Y N Hepatitis
Y N Asthma	Y N HIV+/AIDS
Y N Cancer	Y N Kidney/Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic/Scarlet Fever
Y N Convulsions/Epilepsy	Y N Tuberculosis (TB)

Please discuss any medical problems that you child has had:

Does/did your child have any of the following habits?

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

Neighbor or Relative not living with you:

Name _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

I understand that the information that I have given is current 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 _____

This office reserves the right to verify the credit status of potential and/or parents of patients 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.

Signature of parent or guardian _____ Date _____

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: _____