Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can and **bring it to the Exam Visit.** If you have questions we'll be glad to help you. We look forward to working with your child.

Child's Name_____ Soc. Sec. #_____
(Last) (First) (Initial)

Address_____

City_____ State_____ Zip_____ Phone_____ Sex: M____ F____ Age_____

Birthdate_____ School_____ Grade_____ Hobbies/Sports_____

Mother's Name/Address_____

Father's Name/Address_____

Other family members who are patients here?_____

Whom may we thank for referring you?_____ Dentist_____

Person Responsible for Account_____
(Last) (First) (Initial) (Birthdate)

Relation to Child_____ Soc. Sec. #_____ Home Phone_____

Cell Phone _____ Email _____

Employer of Resp. Party_____ Occupation_____ Business Phone_____

To whom do you want correspondence sent?_____

Primary Orthodontic Insurance

Insurance Company_____ Phone_____ Group #_____
Subscriber Name_____ Relation to Child_____ Birthdate_____ Soc. Sec. #_____
Address (*if different from child*)_____ City_____ State_____ Zip_____
Phone_____ Subscriber Employed by_____ Business Phone_____

Additional Orthodontic Insurance

Insurance Company_____ Phone_____ Group #_____
Subscriber Name_____ Relation to Child_____ Birthdate_____ Soc. Sec. #_____
Address (*if different from child*)_____ City_____ State_____ Zip_____
Phone_____ Subscriber Employed by_____ Business Phone_____

Dental History

Why are you interested in orthodontic treatment for your child?_____
_____
Date of last dental care_____
How often does your child brush?_____ Floss_____
Has your child ever had orthodontic treatment? Yes____ No____
Has your child ever experienced a mouth or chin injury? Yes____ No____
Does your child have any habits/problems affecting the mouth or teeth? (suck thumb/fingers?)_____
Which musical instruments does your child play?_____
Does your child usually breathe through his/her mouth while awake? Yes____ No____ Or asleep Yes____ No____
Has your child ever had a problem during or in conjunction with a medical or dental procedure?_____
Other information about your child's dental health or previous treatment._____

Please complete both sides

Medical History

Child's Physician_____Phone_____Date of last visit_____

Has your child had any serious illnesses or operations? Yes___No___

If yes, describe_____

Taking any medications?_____ List_____

Any allergies to medications?_____

Is your child currently under physician care? Yes___No___If yes, describe_____

Have the child's adenoids or tonsils been removed? Yes___No___

Check (√) if your child has had any of the following:

- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Asthma
- ❑ Allergy Prone
- ❑ Autism
- ❑ Blood disease
- ❑ Cancer
- ❑ Convulsions/ epilepsy
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Emotional disorder
- ❑ Fainting
- ❑ Food allergies
- ❑ Headaches
- ❑ Heart problems
  Need premed?__
- ❑ Hearing impairment
- ❑ Hemophilia/
  abnormal bleeding
- ❑ Kidney disease or
  malfunction
- ❑ Liver disease
- ❑ Material allergies
  (**latex,**wool, metal,
  chemicals)
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Thyroid disease/
  malfunction
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Other_____

1. By signing this form, the undersigned acknowledges that they have legal responsibility for above listed patient.
2. The undersigned hereby authorizes the doctor to do an exam and request any necessary x-rays, study models, photographs or diagnostic aids deemed appropriate.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by both and consent that the doctor choose and employ such assistance as deemed fit to provide quality care.
4. I consent to allowing my child's diagnostic records to be used for professional, educational presentations.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

Payment is due in full at time of treatment, unless prior arrangements have been made.