# Welcome to the Orthodontist

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We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1 Tell us about your Child

Todays Date: ______________________________

**Childs Name:** ______________________________

Nick Name: ______________________________

Child's Birthdate: ______________ Child's Age: ____________

School: ______________________ Grade: __________

Hobbies/Sports: ______________________________

Child's Home #: ______________________________

**Child's Home Address:** ______________________________

______________________________
City State Zip

## 2 Who is Accompanying your Child today?

Name: ______________ Relation: ____________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? ______________________

List brothers/sisters W age: ______________________

______________________________

General Dentist: ______________________________

Last Visit Date: ______________________

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

## 3 Parent Information

Mother's Name: ______________________________
Step Mother ☐ Guardian ☐
Work #: ____________ Ext. ______ Home #: ______________
Employer: ______________________________
SS #: ______________ DL #: ______________
Email: ______________________________

Father's Name: ______________________________
Step Father ☐ Guardian ☐
Work #: ____________ Ext: ______ Home #: ______________
Employer: ______________________________
SS #: ______________ DL #: ______________
Email: ______________________________

## 4 Person Responsible for Account

Name: ______________ Relation: ______________

Billing Address: ______________________________

______________________________
City State Zip

Wk #: ____________ Ext: __________ Hm #: ____________

Employer: ______________________________

DL #: ______________ SS #: ______________

Who is responsible for making appointments?

Name: ______________________________

Work #: ____________ Ext: __________ Hm #: ____________

## 5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, Policy #): ______________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: ____________ & SS #: ____________

Insured's Employer: ______________________________

**Secondary Orthodontic Insurance**

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, Policy #): ______________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: ____________ & SS #: ____________

Insured's Employer: ______________________________

## 6 What are the main concerns that you would like orthodontics to accomplish

______________________________________________
______________________________________________

Has your child ever been evaluted or had orthodontic treatment before?
☐ Yes ☐ No
Has 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 the jaw joint (TMJ / TMD)?
☐ Yes ☐ No
Does your child brush his/her teeth daily? ☐ Yes ☐ No

Floss 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 menustration begun? (Girls) ☐ Yes ☐ No

Please describe you child's current physical health:
☐ Good ☐ Fair ☐ Poor
Please list all drugs that your child is currently taking: __________
______________________________________________

List allergies to medications: __________________________
______________________________________________

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

Y N Allergic to Plastic
Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV + / Aids
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis (TB)
Y N Allergic to Latex/ Metals
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations
Y N Any Stays in a hospital
Y N Kidney / Liver Problems
Y N Handicaps / Disabilities
Y N Allergies to any drugs

**Please discuss any medical problems that your child has had:**

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

## 8 Your child have any of the following habits?

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

## 9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to onform this office of any changes in my child's medical status.

I also 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 patients 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

The parent or Guardian who accompanies the child is responsible for payment.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**Office Use Only** Office Use Only **Office Use Only** Office Use Only **Office Use Only** Office Use Only

I verbally reviewed the medical / dental information above with the patient named herin: Initials _______ Date __________

**Doctor's Comments:**

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________