Welcome

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

Patient Name_____ ❑Male ❑Female

Social Security #_____ Birth Date _____ Age _____

Home Address_____

City _____ State_____ Zip_____

Primary Phone # _____ ❑home ❑cell Ok to leave Message? ❑Y ❑N

Email _____

School _____ Grade_____

List any sports or extracurricular activities _____

Siblings (names and ages) _____

Parent's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Significant Other

❑ Mother ❑ Step-Mother ❑Guardian ❑Other Name_____

Social Security #_____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State_____ Zip_____

Phone # _____ ❑home ❑cell Secondary Phone #_____ ❑home ❑cell

Employer's Name _____ Occupation_____

❑ Father ❑ Step-Father ❑Guardian ❑Other Name_____

Social Security #_____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State_____ Zip_____

Phone # _____ ❑home ❑cell Secondary Phone #_____ ❑home ❑cell

Employer's Name _____ Occupation_____

Emergency Contact Name (other than parent) _____

Phone # _____ Relation to child _____

Address_____

City _____ State_____ Zip_____

Person(s) OK to release appointment or medically related information to concerning child.

_____ Relation(s) _____

Primary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

General Dentist _____ Last Visit _____

How did you hear about our Practice? ❑Ad ❑Internet ❑ Family or Friend ❑Physician ❑Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

_____

Have your child visited an orthodontist before? ❑Y ❑N

When? _____ Reason? _____

Have we treated any other family members? ❑Y ❑N Name _____

Have your child's tonsils or adenoids been removed? ❑Y ❑N

Has your child ever experienced jaw joint pain/ discomfort (TMJ/TMD) ? ❑Y ❑N

Does your child have any missing or extra permanent teeth? ❑Y ❑N

Has your child ever had an injury to (*select all that apply*) : ❑Teeth ❑Mouth ❑Chin

Does your child have speech problems? ❑Y ❑N If so, explain _____

Does your child currently or has your child ever had any of the following habits (*check all that apply*)

❑Clenching/Grinding Teeth ❑Mouth Breathing ❑Thumb/ Finger Sucking

❑Lip Sucking/Biting ❑Nail biting ❑Chewing/Eating Problem

Is your child currently being treated by a physician? ❑Y ❑N Reason _____

Physician _____ Last Visit _____ Phone _____

Does your child have any allergies/sensitivities to medications or latex? ❑Y ❑N If yes, please list.

_____

Is your child currently taking any prescription or over-the-counter medications? ❑Y ❑N

Please list, with dosage. _____

Has puberty and/or menstruation begun? ❑Y ❑N ❑N/A

- 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 child's medical status.
- I hereby authorize the release of any information pertaining to my child's 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.

_____ _____

Patient Signature and/or Responsible Party Date