SPECIALISTS in
ORTHODONTICS

ABOUT YOUR CHILD

Today's Date: ______ Month ______ Day ______ Year ______

Name: ______ Last ______ First ______ Middle ______

Nickname: ______ ☐ M ☐ F

Child's Birthdate: ______ Age: ______

School: ______ Grade: ______

Hobbies/Sports: ______

Child's Home #: ______

Child's Home Address: ______

______ City ______ State ______ Zip ______

List siblings with ages: ______

______

General Dentist: ______

Last Visit Date: ______

PERSON ACCOMPANYING CHILD TODAY

Name: ______

Relation: ______

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

Whom may we thank for referring you? ______

______

Parental Marital Status: ☐ Single ☐ Married

☐ Widowed ☐ Divorced ☐ Separated

MOTHER'S INFORMATION

☐ Guardian
☐ Step Mother

Name: ______ Birthdate: ______

Mobile #: ______ Home #: ______

Email: ______

Employer: ______ Work #: ______ Ext: ______

Social Security #: ______

FATHER'S INFORMATION

☐ Guardian
☐ Step Father

Name: ______ Birthdate: ______

Mobile #: ______ Home #: ______

Email: ______

Employer: ______ Work #: ______ Ext: ______

Social Security #: ______

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Company Name: ______

Insurance Company Address: ______

Insurance Company Phone #: ______

Policy or ID #: ______

Policy Owner's Name: ______

Policy Owner's Address: ______

Relationship to Patient: ______

Policy Owner's Birthdate: ______

Policy Owner's Employer: ______

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Company Name: ______

Insurance Company Address: ______

Insurance Company Phone #: ______

Policy or ID #: ______

Policy Owner's Name: ______

Policy Owner's Address: ______

Relationship to Patient: ______

Policy Owner's Birthdate: ______

Policy Owner's Employer: ______

TERTIARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Company Name: ______

Insurance Company Address: ______

Insurance Company Phone #: ______

Policy or ID #: ______

Policy Owner's Name: ______

Policy Owner's Address: ______

Relationship to Patient: ______

Policy Owner's Birthdate: ______

Policy Owner's Employer: ______

APPOINTMENT REMINDER PREFERENCE

☐ Phone Calls ☐ Text Messages ☐ Emails

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

____
____
____
____

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 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

Floss 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

Please describe your child's current physical health: ☐Good ☐Fair ☐Poor

Has puberty begun? ☐ Yes ☐ No

DOES YOUR CHILD NEED TO BE ON AN ANTIBIOTIC BEFORE DENTAL TREATMENT? ■ Yes ■ No

Please list all medications that your child is currently taking:

____
____

Please list anything that your child is allergic to:

____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

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

Please discuss any medical problems that your child has had:

____
____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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

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 confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize the dental staff to perform any necessary dental service with my informed consent that I may need during diagnosis and treatment. Also, I guarantee payment of all fees for treatment.

Assignment of Benefits: I hereby authorized payment to my attending Orthodontist. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that where appropriate credit bureau reports may be obtained.

____
Signature Date

MEDICAL HISTORY UPDATES

FOR OFFICE USE ONLY

Changes: ______________ Date: ________

Parent/Guardian Signature: ______________

Dental Staff Signature: ______________

Changes: ______________ Date: ________

Parent/Guardian Signature: ______________

Dental Staff Signature: ______________

Changes: ______________ Date: ________

Parent/Guardian Signature: ______________

Dental Staff Signature: ______________

Changes: ______________ Date: ________

Parent/Guardian Signature: ______________

Dental Staff Signature: ______________