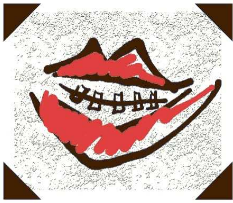

WELCOME

Date: ________________

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 for your cooperation.

Tell us about your child

Child's Name: ______________________________

Preferred Name: ______________________________

Birthdate: ____/____/____ Child's Age: _____ Sex: ______

School: ______________________________

Hobbies / Sports: ______________________________

Home #: ______________________________

Home Address: ______________________________

____

Who is Accompanying your Child Today?

Name: ________________Relation: ____________

Do you have legal custody of this child? Yes No

List brothers/sisters & birthdates:____________________

____

General Dentist: ______________________________

Last Visit Date: ______________________________

Parent's Marital Status: ______________________________

Mother's Information:

Name: ______________________ ____________

H#: ____________ W#____________ C# ____________

Employer: ______________________________

Occupation: ______________________________

SSN: ______________ Email: ________________

Father's Information:

Name: ______________________________

H#: ____________ W#____________ C# ____________

Employer: ______________________________

Occupation: ______________________________

SSN: ____________ Email: ________________

Person Responsible for Account

Name: ______________________________

Billing Address: ______________________________

____

H#: ____________ W#____________ C# ____________

Employer: ______________________________

Occupation: _______________SSN: ______________

Who is responsible for making appointments?

Name: ______________________________

H#: ____________ W#____________ C#____________

Primary Dental Insurance

Orthodontic Coverage? Yes No

Ins. Co. Name: ______________________________

Ins. Co. Address: ______________________________

Ins. Co. Phone #: ______________________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthdate: ____/____/___ & SSN: ____________

Insured's Employer: ______________________________

Secondary Dental Insurance

Orthodontic Coverage? Yes No

Ins. Co. Name: ______________________________

Ins. Co. Address: ______________________________

Ins. Co. Phone #: ______________________________

Group # (Plan, Local, or Policy #): ________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthdate: ____/____/___ & SSN: ____________

Insured's Employer: ______________________________

What are the Main Concerns that you would like Orthodontics to Accomplish?

____

____

Has there been any injuries to the face, mouth, teeth or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing permanent teeth? Yes No

Has your child been informed of any extra 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

Has puberty begun? Yes No

Has menstruation begun (females)? Yes No

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

Has your child ever been told that he/she must take antibiotics prior to dental appointments? Yes No

Child's Physician: ____________________________

Physician's Phone #: ____________________________

Date of Last Visit: ____________________________

Has your Child ever had any of the following Medical Problems?

Y	N	Seasonal Allergies	Y	N	Allergy to Latex/Metals
Y	N	Heart Murmur	Y	N	Congenital Heart Disease
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+ / AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a Hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis	Y	N	Allergies to any Drugs

Please discuss any medical problems that your child has had:

____

Please list all drugs that your child is currently taking:

____

Please list all drugs that your child is allergic to:

____

Does your Child have any of the following Habits?

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

WHOM MAY WE THANK YOU FOR REFERRING YOU? ____

Is your child self-conscious of his/her teeth? Yes No

Has your child ever been evaluated or had Orthodontic treatment? Yes No

If Yes, by whom? ________________________________

What do you consider to be the main benefits of Orthodontic Correction?
☐ Cosmetic ☐ Functional ☐ Psychological/Emotional ☐ Other

What is your child's attitude toward Orthodontic treatment?
☐ Enthusiastic ☐ Indifferent ☐ Resentful

I understand that the information which 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 inform the 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. 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 the office, use the services of one or more credit reporting services.

________________________________ ________________________

Signature of parent or guardian **Date**