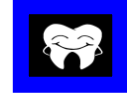
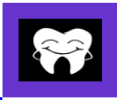




Welcome



Patients Name _____ Preferred Name _____ Sex _____

Address _____ City _____ Zip _____

Patient resides with: Mother Father Both Other _____

Home Phone _____ Age: _____ Birth date _____ School: _____ Grade _____

Please describe your child's orthodontic problems in your own words: _____

Patients Interests: _____

Whom may we thank for referring you to our office? _____

Do you know a patient currently in our practice? If so whom? _____

PARENTS AND ACCOUNT INFORMATION

Parents Marital Status: Married Separated Divorced Widowed Single
Father Mother

Name _____

Address _____

City, State, Zip _____

Home Phone _____

Cell/Business _____

Email Address _____

Occupation/Employer _____

Person responsible for account: _____

If other than parent

Name _____ Address _____ Phone _____

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize creditor or his agent to make a credit investigation, including employment verification.

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance company _____ Group # or SS# _____

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance company _____ Group # or SS# _____

FINANCIAL AND INSURANCE INFORMATION

I understand that I am financially responsible for any charges (including collection fees); and that I am responsible for knowledge of my insurance program and its limitations. This office is not responsible for knowing my insurance benefits and limitations. I understand that I may request a copy of this form. I have read this authorization and understand its contents.

Signature _____ Date _____

Responsible Person for Payment

We love to make people smile!

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential

Medical History

Physician's Name: _____ Address _____ Phone _____

Has your child experienced any health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Any major change in your child's health recently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Is your child currently under physician's care?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Is your child currently taking medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes	List:
Is your child allergic to any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes	List:
Has your child received a blood transfusion?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Reason:
Have your child's tonsils or adenoids been removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Has your child been in a risk group for AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain

Please check if your child has had any of the following conditions?

Heart Murmur _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Emotional Problems _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Surgery _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent Headaches _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervous/Anxious _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocrine Disorders _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver Disease _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Anemia _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bone Disorder _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Prolonged Bleeding _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Growth Disorder _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blood Disease _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mouth Breather _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Developmental Disorder _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Herpes (Fever Blister) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hives/Rash _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fainting _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tonsillitis _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Are there any other conditions or problems that you think we should know about? _____

Comments _____

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Girls-Has she started menstruation?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When?
Boys-Has his voice changed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When?
Do you feel growth is completed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Current Height _____ Father's Height _____ Mother's Height _____
Adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Names and Birthdates of patient's brothers and sisters:		Please list-
Have either siblings or parents had orthodontic treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	With whom:
Any family history of growth disorders? (underbite, overbite, etc)		Please list-

Dental History

Dentist Name: _____ Address _____ Phone _____

Frequency of dental checkups: Twice a year Once a Year Only if a problem exists Never Date of last Visit _____

Is there any unfinished care to be completed with your child's dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Is your child frightened about dental treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Has your child had an unpleasant experience in a dental office?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Has your child had any facial or dental injuries?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Does your child play any musical instrument?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What instrument?
Has your child consulted an orthodontist previously?	<input type="checkbox"/> No <input type="checkbox"/> Yes	With whom?
Have teeth (either baby or permanent) been removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Has your child had any previous orthodontic treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	With whom?
Are you satisfied with prior treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:

Please check if there is a history of:

<input type="checkbox"/> Clenching teeth	<input type="checkbox"/> Muscular soreness around head and neck	<input type="checkbox"/> Jaw joint soreness	<input type="checkbox"/> Jaw joint popping
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Headaches (more than normal)	<input type="checkbox"/> Jaw joint clicking	<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Speech problems (If so, which sounds _____)		<input type="checkbox"/> Mouth breathing: Awake _____ Asleep _____	

Is there any other information that may be helpful? _____

Parent's Signature _____ Date _____ Reviewed by: _____