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# _____

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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?	☐No ☐ Yes	Explain
Any major change in your child's health recently?	☐No ☐ Yes	Explain
Is your child currently under physician's care?	☐No ☐ Yes	Explain
Is your child currently taking medications?	☐No ☐ Yes	List:
Is your child allergic to any medications?	☐No ☐ Yes	List:
Has your child received a blood transfusion?	☐No ☐ Yes	Reason:
Have your child's tonsils or adenoids been removed?	☐No ☐ Yes	When:
Has your child been in a risk group for AIDS?	☐No ☐ Yes	Explain

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

Heart Murmur	☐No ☐Yes	Hepatitis	☐No ☐Yes	Emotional Problems	☐No ☐Yes
Heart Surgery	☐No ☐Yes	Diabetes	☐No ☐Yes	Frequent Headaches	☐No ☐Yes
Rheumatic Fever	☐No ☐Yes	Kidney Disease	☐No ☐Yes	Nervous/Anxious	☐No ☐Yes
Endocrine Disorders	☐No ☐Yes	Liver Disease	☐No ☐Yes	Cancer	☐No ☐Yes
Anemia	☐No ☐Yes	Tuberculosis	☐No ☐Yes	Bone Disorder	☐No ☐Yes
Prolonged Bleeding	☐No ☐Yes	Bronchitis	☐No ☐Yes	Growth Disorder	☐No ☐Yes
Blood Disease	☐No ☐Yes	Asthma	☐No ☐Yes	Mouth Breather	☐No ☐Yes
Developmental Disorder	☐No ☐ Yes	Epilepsy	☐No ☐Yes	Herpes (Fever Blister)	☐No ☐Yes
Hives/Rash	☐No ☐ Yes	Fainting	☐No ☐Yes	Tonsillitis	☐No ☐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?	☐No ☐ Yes	
Girls-Has she started menstruation?	☐No ☐ Yes	When?
Boys-Has his voice changed?	☐No ☐ Yes	When?
Do you feel growth is completed?	☐No ☐ Yes	Current Height_____ Father's Height_____ Mother's Height_____
Adopted?	☐No ☐ Yes	
Names and Birthdates of patient's brothers and sisters:		Please list-
Have either siblings or parents had orthodontic treatment? ☐No ☐ 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?	☐No ☐ Yes	Explain:
Is your child frightened about dental treatment?	☐ No ☐ Yes	Explain:
Has your child had an unpleasant experience in a dental office?	☐ No ☐ Yes	Explain:
Has your child had any facial or dental injuries?	☐ No ☐ Yes	Explain:
Does your child play any musical instrument?	☐ No ☐ Yes	What instrument?
Has your child consulted an orthodontist previously?	☐ No ☐ Yes	With whom?
Have teeth (either baby or permanent) been removed?	☐ No ☐ Yes	
Has your child had any previous orthodontic treatment?	☐ No ☐ Yes	With whom?
Are you satisfied with prior treatment?	☐ No ☐Yes	Explain:

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint soreness ☐ Jaw joint popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears

☐ Speech problems (If so, which sounds_____) ☐ Mouth breathing: Awake___ Asleep ___

Is there any other information that may be helpful?_____

Parent's Signature_____ Date _____ Reviewed by:_____