WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: ____________ ☐ Male ☐ Female

Child's Name: ______________________ (LAST / FIRST / MI)

Nickname: ______________________ (CHILD PREFERS TO BE CALLED) SS#: ______________

Child's Birthdate: ____________ Child's Age: ______________

School: ______________________ Grade: ______________

Hobbies / Sports: ______________________________

Child's Home #: ______________________________

Child's Home Address: ______________________ (APT/CONDO #)

______________________ (CITY / STATE / ZIP)

E-Mail Address: ______________________________

2 Who Is Accompanying Your Child Today?

Name: ______________________ Relation: ______________

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

Whom may we Thank for referring you? ______________________

List brothers / sisters with age:

General Dentist: ______________________________

Last Visit Date: ______________________________

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: ______________________ Birthdate: ______________

Email Address: ______________________________

Cell #: ______________ Hm #: ______________

Employer: ______________ Wk #: ______________

SS #: ______________ DL #: ______________

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: ______________________ Birthdate: ______________

Email Address: ______________________________

Cell #: ______________ Hm #: ______________

Employer: ______________ Wk #: ______________

SS #: ______________ DL #: ______________

4 Person Responsible For Account

Name: ______________________ Relation: ______________

Billing Address: ______________________________

______________________ (CITY / STATE / ZIP)

Previous Address: ______________________________

______________________ (CITY / STATE / ZIP)

Hm #: ______________ DL #: ______________

Employer: ______________________________

Wk #: ______________ Ext: _____ SS #: ______________

Who is responsible for making appointments?

Name: ______________________________

Wk #: ______________ Ext: _____ Hm #: ______________

Neighbor or Relative not living with you.

Name: ______________________ Phone: ______________

Address: ______________________________

______________________ (CITY / STATE / ZIP)

5 Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

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

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ______________ SS #: ______________

Policy Owner's Employer: ______________________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

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

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ______________ SS #: ______________

Policy Owner's Employer: ______________________________

CONTINUED ON BACK

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

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 any 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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when?

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

Please list all drugs/things that your child is allergic to:

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD / ADHD
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 Artificial Bones / Joints / Valves
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 Problems
Y N Liver Problems
Y N Lupus
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

Does/did 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
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Was your child breast fed? Y N

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

My method of payment will be: ____________________________

Signature of parent or guardian Date

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 this office, use the services of one or more credit reporting services.

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: ____________ Date: ____________

BLUE SKY **FORM #ORTHO-2C3** **www.informsonline.com** **© 2013** INFORMS **1-800-722-4884**