Welcome

Confidential Patient Information

Date: ____________

Patient's Name: ____
Last First Middle

Nickname: ____________________ Gender: ____ School: ____________________

Address: ____
Street City State Zip

Home Phone: (____)______________ Birthdate: ____/____/____ Social Security # ____________________

Hobbies / Sports / Interests: ____

General DDS: ____________________ Date of last cleaning: ____________________

If patient is a minor, give parent's or guardian's name: ____________________

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

Confidential Responsibile Party Information

Name: ____ Marital Status: ____________
Last First Middle

Residence: ____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address: ____
Street City State Zip

How long at this address: __________ Home phone: (____)____________ Work Phone: (____)____________

Previous Address: (if less than 3 yrs.) ____
Street City State Zip

Email address: ____

Social Security # ____________ Birthdate: ____/____/____ Relationship to Patient: ____________

Employer: ____________ No. Years Employed: ____________ Occupation: ____________

Spouse's Name: ____ Relationship to Patient: ____________
Last First Middle

Employer: ____________ No. Years Employed: ____________ Occupation: ____________

Social Security # ____________ Birthdate: ____/____/____ Work Phone: (____)____________

Insurance Information

Policy Holder's Name: ____________________ Soc. Security # ____________

Insurance Company: ____________ Group No. ____________ Union Local No. ____________

Insurance Co. Address: ____________________ Insurance Co. Phone: (____)____________

Policy Holder's Employer: ____

Do you have dual coverage? No ☐ Yes ☐ If yes: ____________________

Policy Holder's Name: ____________________ Soc. Security # ____________

Insurance Company: ____________ Group No. ____________ Union Local No. ____________

Insurance Co. Address: ____________________ Insurance Co. Phone: (____)____________

Policy Holder's Employer: ____

Continued on back

What would you like orthodontics to accomplish?

____

Has your child ever taken Phen-Fen? ☐ Y ☐ N
(Redux or Pondimin) If yes, when? ________________

Has your child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth, or chin? ☐ Y ☐ N

List any musical instruments played: ________________

Have adenoids or tonsils been removed? ☐ Y ☐ N

Has your child been informed of any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Y ☐ N

Does your child brush his / her teeth daily? ☐ Y ☐ N

Does your child floss his / her teeth daily? ☐ Y ☐ N

Child's Physician : ________________________

Phone: (____)__________ Date of last visit: ________

Is your child under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

Girls - has menstruation begun? ☐ Y ☐ N

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 alleric to:

____

Latex Y N Metals/Nickel Y N Plastics Y N

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

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

Please discuss any medical problems that your child has had :

____

____

Has your child ever experienced any of the following?

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

Neighbor or Relative not living with you :

Name: __________________ Phone: (____)____________

Address: ________________________________
Street

____
City State Zip

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my childs medical status.

I authorize the dental staff to perform the necessary dental services that my child may need.

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SIGNATURE OF PARENT / 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.

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SIGNATURE OF PARENT / GUARDIAN DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

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SIGNATURE OF PARENT / 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

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

Doctor's Comments : ________________________ Initials :________ Date: __________

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