Welcome To Our Office!

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Diplomate American Board of Orthodontics
Specialty #5308

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PLEASE TELL US ABOUT YOUR CHILD

Today's Date: ______________________

Name: ______________ MI: ____ Last Name: ______________________ Nickname: __________

DOB: __________ Age: ____ Gender: ____ Grade: ____ Parent's Cell: ______________

Address: __________________________ City: ______________________

State: ________ Zip: ______________ SS#: ______________________

Child's Hobbies & Interests: ______________________________

Other children in the family & ages: ______________________________

Who may we thank for this referral? ______________________________

PARENT/GUARDIAN INFORMATION

☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Single ☐ Widowed

Father: ☐ Mr. ☐ Dr. First Name: ______________ Last Name: ______________

Address (if different): ______________________ Town: ____________ Zip: ______

Email Address: ______________________ Home Phone: ____________ Cell: __________

Mother: ☐ Mrs. ☐ Dr. ☐ Ms. First Name: ______________ Last Name: ______________

Address (if different): ______________________ Town: ____________ Zip: ______

Email Address: ______________________________ Cell: ______________

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible for this account: ______________________________

Relationship to Patient: ______________________________

DOB: ______________________ SS#: ______________________

Cell Phone: ______________________________

Email Address: ______________________________

Employer: ______________________________

Is it okay to contact you at work? __________ Business Phone: ______________________

INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Co: ______________________

Insurance Address: ______________________

Phone #: ______________________

Member ID: ______________________

Group # (plan, local or policy): ______________

Subscriber: ______________________

Relation to Patient: ______________________

Employer: ______________________

Birthdate: ____________ SS#: ____________

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co: ______________________

Insurance Address: ______________________

Phone #: ______________________

Member ID: ______________________

Group # (plan, local or policy): ______________

Subscriber: ______________________

Relation to Patient: ______________________

Employer: ______________________

Birthdate: ____________ SS#: ____________

I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination, rendered to my insurance company.

Signature on file for insurance ______________________________ Date ______________

MEDICAL AND DENTAL HISTORY

Please answer the following questions to the best of your knowledge

Family/Patient's Dentist: ______________________ Office Phone: ______________

Address: ______________________ City: ____________ State: ________ Zip: ____________

Physician's Name: ______________________ Office Phone: ______________

Address: ______________________ City: ____________ State: ________ Zip: ____________

1. Is your child now or has he/she ever been under a physician's care? ☐ Yes ☐ No
2. Has your child ever been hospitalized? Yes ☐ No ☐ REASON ______________________
3. Allergies: food, pollen, drugs? Yes ☐ No ☐ EXPLAIN ______________________
4. Any medical problems? Yes ☐ No ☐

☐ Heart ☐ Kidneys ☐ Lungs ☐ Liver ☐ Blood Disorders ☐ Other ______________________

5. Were his/her tonsils or adenoids removed? ☐ Yes ☐ No
6. Has any physician/dentist ever indicated that antibiotics (E.G. Penicillin) be taken prior to a dental procedure? ☐ Yes ☐ No
7. Any recent sudden increase in height? Yes ☐ No ☐
8. Sign of puberty? ☐ Yes ☐ No (This question is helpful in determination of growth potential which could be critical in orthodontic treatment)
9. What is your main concern in regards to your teeth / bite? ______________________

____

10. Who first suggested the need for an orthodontic consult / treatment?

☐ Parents ☐ Patient ☐ Dentist ☐ Other ______________________

11. Previous orthodontic treatment/ consult? ☐ Yes ☐ No May we ask where ______________________
12. Is there clicking / popping / discomfort with the jaw joints? ☐ Yes ☐ No
13. Are you aware of any grinding or clenching of teeth? ☐ Yes ☐ No
14. Speech or other oral / dental problems? Yes ☐ No ☐
15. When was your last visit to a general dentist?

☐ Recent ☐ 6 or more months ago ☐ more than a year ago ☐ Don't remember

16. Gag reflex? ☐ Yes ☐ No
17. History of facial / tooth trauma? ☐ Yes ☐ No If yes, please explain ______________________

____

18. Oral habits: ☐ Thumb / Finger sucking ☐ Lip / Nail biting ☐ Mouth breathing ☐ Tongue thrust

Any other diagnoses you would like to include? ______________________

*I, the undersigned, give consent to release my information to the emergency contact listed here:

______________________ ______________________ ______________________

First and Last Name Relationship to Patient Contact

*I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. Also, I give consent for this examination and I am legally authorized to do so.

______________________ ______________________

*Today's date *Parent/Guardian Signature Required