

Welcome to our office

We are pleased to welcome you and your family to our office. Please ask your parents to take a few minutes to fill out this form as completely as possible and bring it with you to your initial examination appointment. We look forward to meeting you!

Patient Information

School: _____ Grade: _____ Patient lives with: Mother Father Both Other _____

Father's name: _____ Employer: _____ Bus phone: _____ E-Mail _____

Mother's name: _____ Employer: _____ Bus phone: _____ E-Mail _____

Names and ages of other children in the family: _____

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

Account Information

A consumer credit report may be ordered in connection with payment arrangements or subsequently with update, renewal or extension of credit. Upon your request, you will be informed whether or not a consumer report was ordered, and if it was, you will be given the name and address of the consumer reporting agency that furnished that information.

Person responsible for account: _____ Relation: _____

If other than patient or parent previously indicated:

Home address: _____ City: _____ Zip: _____ Phone: _____

Occupation: _____ Employer: _____ Bus. Phone: _____

Length of employment _____

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the person responsible for the account is responsible for all fees incurred. For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

Insured _____ Insured _____

ID# _____ DOB _____ ID# _____ DOB _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Insurance Co. _____ Insurance Co. _____

Insurance Address: _____ Insurance Address: _____

Phone # _____ Group # _____ Phone # _____ Group # _____

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 confidential under the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

Medical History

Physicians Name: _____ Phone: _____ Last visit: _____

	No	Yes	
Is patient in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Physical exam: _____
Is patient currently under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	For what condition? _____
Is patient currently taking any medicines or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	List _____
Is patient allergic to any medications?.....	<input type="checkbox"/>	<input type="checkbox"/>	List _____
Has the patient ever been treated for mental or nervous disorders?...	<input type="checkbox"/>	<input type="checkbox"/>	List _____
Has the patient ever had any serious illness, operation or been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	List _____
Has the patient had tonsils or adenoids been removed?.....	<input type="checkbox"/>	<input type="checkbox"/>	When? _____

Please check if the patient has had any of the following conditions:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Fainting/Dizzy Spells |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS or HIV infection |
| <input type="checkbox"/> Other Heart Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes (Fever Blisters) |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Growth or Bone Disorder | <input type="checkbox"/> Other Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |

Height: _____ Weight: _____ Does the patient wear contact lenses? No Yes

Is there any other medical information we should know about? _____

Growth information for patients under 16 years of age

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?..... Yes No

Girls-Has she started menstruation?..... Yes No When? _____

Boys-Has his voice changed?..... Yes No When? _____

Height _____ Do you feel growth is completed? Yes No Father's height _____ Mother's height _____

Dental History

Dentist's name: _____ Phone: _____ Last visit: _____

Frequency of dental check-ups: Twice a year Once a year Only if problem exists Never

	No	Yes	Please explain
Has the patient ever had dental injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does the patient play any musical instruments?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has the patient had any previous orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has the patient had any gum problems or treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has the patient had any complications associated with dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have either siblings or parents had orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is there a history of: (Please mark those which apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Thumb/Finger sucking | <input type="checkbox"/> Clenching your teeth | <input type="checkbox"/> Jaw joint or muscle soreness |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Grinding your teeth | <input type="checkbox"/> Jaw joint popping or clicking |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Jaw joint locking | <input type="checkbox"/> TMJ Therapy |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Other _____ |

Is there any other dental information we should know about? _____

My signature confirms I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and all information is true.

Patient/Parent signature _____ Date _____

Thank you for your time and patience in supplying this important information.