

# 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: \_\_\_\_\_ Nickname: \_\_\_\_\_  
CHILD PREFERS TO BE CALLED

**Child's Name:** \_\_\_\_\_  
LAST FIRST MI

E-mail Address: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  Male  Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_

**Child's Home Address:** \_\_\_\_\_  
APT/CONDO #

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## 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  Partnered  Divorced  
 Married  Separated  Widowed

## 3

### Parent: Mother Father Step Parent Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

### Parent: Father Mother Step Parent 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 #: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

### Who is responsible for making appointments?

Name: \_\_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: \_\_\_\_\_

## 5

### Primary Orthodontic Insurance

Orthodontic 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Secondary Orthodontic Insurance

Orthodontic 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_



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

Has your child ever been prescribed Fosamax  Yes  No or any other bisphosphonate? If yes, when? \_\_\_\_\_

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

**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:** \_\_\_\_\_

Latex  Metals/Nickel  Plastics



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

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal Bleeding                  | <input type="checkbox"/> Convulsions / Epilepsy    |
| <input type="checkbox"/> ADD / ADHD                         | <input type="checkbox"/> Covid-19                  |
| <input type="checkbox"/> Allergies to any Drugs             | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Allergic to Latex / Metals         | <input type="checkbox"/> Handicaps / Disabilities  |
| <input type="checkbox"/> Allergic to Plastic                | <input type="checkbox"/> Hearing Impairment        |
| <input type="checkbox"/> Any Hospital Stays                 | <input type="checkbox"/> Heart Murmur              |
| <input type="checkbox"/> Any Operations                     | <input type="checkbox"/> Hemophilia                |
| <input type="checkbox"/> Artificial Bones / Joints / Valves | <input type="checkbox"/> Hepatitis                 |
| <input type="checkbox"/> Asperger Syndrome                  | <input type="checkbox"/> HIV+ / AIDS               |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Kidney / Liver Problems   |
| <input type="checkbox"/> Autism                             | <input type="checkbox"/> Lupus                     |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Congenital Heart Defect            | <input type="checkbox"/> Tuberculosis (TB)         |

Has your child received Covid-19 vaccinations?  Yes  No  
Type? \_\_\_\_\_ Date(s)? \_\_\_\_\_

**Please discuss any medical problems that your child has had:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Has your child ever experienced any of the following?**

- |   |   |
|---|---|
| <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Nursing Bottle Habits  |
| <input type="checkbox"/> Lip Sucking / Biting       | <input type="checkbox"/> Speech Problems        |
| <input type="checkbox"/> Mouth Breather             | <input type="checkbox"/> Thumb / Finger Sucking |
| <input type="checkbox"/> Nail Biting                | <input type="checkbox"/> Tongue Thrust          |

**Neighbor or relative not living with you in case of emergency.**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

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 of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

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 \_\_\_\_\_

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

Signature of parent or 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. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_