WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

PATIENT INFORMATION

Last Name: __________________________ First Name: _________________________ Middle: _________Sex: _______

Address: __________________________________ ____________________________ __________ ______________
Street City State Zip

Birthdate: ____________ General Dentist: ____________________________ Last Visited: ________________________

Home Phone: ______________________Whom may we thank for referring you to our office? _____________________

PARENT INFORMATION

Father's Name: ________________________ ___________________________ Birthdate: ________________________
Last First

Father's Cell # or preferred Contact #: _______________________ Father's e-mail ______________________________

Father's Employer: ___________________________ Occupation: _______________________ Number of years: ______

Father's Address (if different from child's) _______________________________ __________________ _______ ________
Street City State Zip

Mother's Name: _______________________ ___________________________ Birthdate: ________________________
Last First

Mother's Cell # or preferred Contact #: ______________________ Mother's e-mail ______________________________

Mother's Employer: __________________________ Occupation: _______________________ Number of years: ______

Mother's Address (if different from child's) _______________________________ __________________ _______ ________
Street City State Zip

Dental / Orthodontic Insurance Information

If you have an insurance card, you may give to the front desk to gather most of the following information.

Policy Holder's Name: ________________________________ Policy Holder's Employer: __________________________

Insurance Company: ____________________________________ Insurance Company Phone #: ____________________

Insurance Company's Address: _______________________________ ______________________ _______ __________
Street City State Zip

Group / Policy #: _______________________ Policy Holder's Social Security #: _______-______-______

General Information

School: ____ Grade: __________

Hobbies / Sports: _________________________________ Siblings (include age): ____________________________

____ ____________________________

____ ____________________________

Medical History

Medical Physician: ______________________________ Phone: ________________________ Last Visit: _______________

Is the child currently under the care of a physician? Yes______ No_____ If yes, please explain:______________________

___

Has puberty begun? Yes _______ No ________ Has menstruation begun? Yes ______ No ______

What are the main concerns that you would like orthodontic treatment to accomplish? ____________________________

___

Has the patient ever been evaluated for orthodontic treatment? Yes _____ No _____

Have the patient's tonsils or adenoids been removed? Yes _____ No _____

Has the patient ever experienced jaw joint pain / discomfort (TMJ/TMD)? Yes _____ No _____

Does the patient have any missing or extra permanent teeth? Yes _____ No _____

Has the patient ever had an injury to: (circle all that apply) Teeth Mouth Chin

Has the patient had any of the following habits? (Circle all that apply) Lip Sucking Nail biting Mouth Breather

Prolonged Bottle/Pacifier Clenching/Grinding Teeth Tongue Thrusting Thumb/Finger Sucking

Does the patient have speech problems? Yes _____ No _____ If yes, explain: ___________________________________

____

Is the child allergic to any of the following? (Circle all that apply) Aspirin Codeine Erythromycin

Penicillin Tetracycline Latex Any Metals / Plastics Other: ____________________

I understand that the information that I have provided 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.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form: ______________________________________ Date: ____________________