

# 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  
We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

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## TELL US ABOUT YOUR CHILD

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last First M. Ini.

Child's Birthdate: \_\_\_\_\_ Age \_\_\_\_\_

Nickname: \_\_\_\_\_  Male  Female

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

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

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

Child's Home Address: \_\_\_\_\_

City State Zip

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## WHO IS ACCOMPANYING THE CHILD TODAY?

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

Do you have legal custody of this child?  Y  N

Whom may we Thank for referring you? \_\_\_\_\_

List brothers/sisters with age: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Last Exam Date: \_\_\_\_\_ Any cavities? \_\_\_\_\_

Parent's Marital Status:  Single  Married

Widowed  Divorced  Separated

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## PARENT'S INFORMATION

**Mother**  Step Mother  Guardian

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

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

Employer: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Title: \_\_\_\_\_

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

**Father**  Step Father  Guardian

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

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

Employer: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Title: \_\_\_\_\_

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

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## PERSON RESPONSIBLE FOR ACCOUNT

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

Billing Address: \_\_\_\_\_

City State Zip

Previous Address: \_\_\_\_\_

Hm#: ( ) \_\_\_\_\_ DL#: \_\_\_\_\_

Employer: \_\_\_\_\_

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

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

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## PRIMARY DENTAL INSURANCE

Dental Coverage?  Yes  No Ortho?  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 DOB: \_\_\_\_\_

Policy Owner's SS#: \_\_\_\_\_

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## DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING?

Y N Clenching/Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Speech Problems

Y N Thumb/Finger Sucking

Y N Tongue Thrust

Please Fill Out Page Two of This Form

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WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

\_\_\_\_\_  
-  
\_\_\_\_\_  
-  
\_\_\_\_\_

Has the 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 the child even had any pain / tenderness in his / her jaw joint (TMI/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: \_\_\_\_\_

Phone#: ( ) \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

- Good  Fair  Poor

Please list all drugs that the child is currently taking:

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

Please list all drugs/things that the child is allergic to:

\_\_\_\_\_

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HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

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

I understand that the information that I have given is correct to the best of my knowledge, that is 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 authorize the dental staff to perform the necessary dental services my child may need.

\_\_\_\_\_  
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent / guardian & patient named herein.  
Doctor's Comments Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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