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 year child to have a beautiful smile that lasts a lifetime.

PLEASE FILL OUT THIS FORM COMPLETELY.

TELL US ABOUT YOUR CHILD

Today's Date: _____/______/______ Last Visit Date: _____/______/______

CHILD'S NAME: ____
First M Last

Nickname:: ____________________________ ❑ Male ❑ Female

Date of Birth: _____/______/______ Age: ____ SS#: ________________

School: __________________________________ Grade: ____________

Hobbies/Sports: ____

Home Address:____
Street Address Apt/Condo #

____
CITY STATE ZIP

E-Mail Address: ____

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 ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

MOTHER'S INFORMATION: ❑ STEP MOTHER ❑ GUARDIAN

Name: ___________________________ Date of Birth: ____/_____/_____

Home #: (______)_______________ Work #: (______)_______________

Employer: ____

How Long at Current Job: _________ Job Title: ________________________

SS#: ____________________ Drive License #: ____________________

FATHER'S INFORMATION: ❑ STEP FATHER ❑ GUARDIAN

Name: ___________________________ Date of Birth: ____/_____/_____

Home #: (______)_______________ Work #: (______)_______________

Employer: ____

How Long at Current Job: _________ Job Title: ________________________

SS#: ____________________ Drive License #: ____________________

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _________________________ Relation: ____________________

Billing Address: ____
Street Address Suite #

____
CITY STATE ZIP

Previous Address: ____
Street Address Suite #

____
CITY STATE ZIP

Employer: ____

Work #: (______)_______________ Home #: (______)_______________

SS#: ____________________ Drive License #: ____________________

Who is responsible for making appointments?

Name: ____

Home #: (______)_______________ Work #: (______)_______________

Neighbor or Relative not living with you.

Name: ______________________ Home #: (______)_______________

Address: ____

PRIMARY INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: ______________________________________

Insurance Co. Address:_____________________________________

Insurance Co. Phone #: (______)________________

Group# (Plan, Local or Policy #): ____________________________

Policy Owner's Name: _______________________ Relation: ___________

Policy Owner's Date of Birth: ____/_____/____ Insured's ID #:____________

Policy Owner's Employer: ___________________________________

SECONDARY INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: ______________________________________

Insurance Co. Address:_____________________________________

Insurance Co. Phone #: (______)________________

Group# (Plan, Local or Policy #): ____________________________

Policy Owner's Name: _______________________ Relation: ___________

Policy Owner's Date of Birth: ____/_____/____ Insured's ID #:____________

Policy Owner's Employer: ___________________________________

HEALTH HISTORY

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

____

Has your child ever been evaluated or had orthodontic treatment? ❑ Yes ❑ No

Has your child ever had an injury to: ❑ Face ❑ Mouth ❑ Teeth ❑ Chin

List any musical instruments played? ______________________________

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has you 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

If yes, when was menstrual?

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:

____

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

Condition	Yes	No
Abnormal Bleeding	❑ Yes	❑ No
ADD /ADHD	❑ Yes	❑ No
Allergies to any Drugs	❑ Yes	❑ No
Allergic to Latex/Metals	❑ Yes	❑ No
Allergic to Plastic	❑ Yes	❑ No
Any Hospital Stays	❑ Yes	❑ No
Any Operations	❑ Yes	❑ No
Artificial Bones/Joints/Valves	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Congenial Heart Defect	❑ Yes	❑ No
Convulsions/Epilepsy	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Handicaps/Disabilities	❑ Yes	❑ No
Hearing Impairment	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
HIV+/AIDS	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No
Liver Problems	❑ Yes	❑ No
Lupus	❑ Yes	❑ No
Rheumatic/Scarlet Fever	❑ Yes	❑ No
Sickle Cell Disease/Traits	❑ Yes	❑ No
Tuberculosis (TB)	❑ Yes	❑ No

Please discuss any medical problems that your child had:

____

____

____

DOES/DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Habit	Yes	No
Clenching/Grinding Teeth	❑ Yes	❑ No
Lip Sucking/Biting	❑ Yes	❑ No
Mouth Breather	❑ Yes	❑ No
Nail Biting	❑ Yes	❑ No
Nursing Bottle	❑ Yes	❑ No
Speech Problems	❑ Yes	❑ No
Thumb/Finger Sucking	❑ Yes	❑ No
Tongue Thrust	❑ Yes	❑ No
Was your child breast fed?	❑ Yes	❑ No

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

____

SIGNATURE OF PARENT OR GUARDIAN: DATE

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 the office, use the services of one or more credit reporting services.

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SIGNATURE DATE

I authorize payment of dental benefits in accordance with my current insurance policy to Precision Orthodontics, LLC for professional services rendered. I understand that I am responsible for the payment and also responsible for any co-payment and deductibles that my insurance does not cover.

____

SIGNATURE DATE

The Parent or Guardian who accompanies the child is responsible for payment.

I acknowledge that I have received a notice of Privacy Practices from Precision Orthodontics.

____

SIGNATURE DATE

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

I verbally reviewed the medial/dental information above with the patient named herein.

Initials: _______________ Date: ____/_____/_____

Doctors Comments:

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