Welcome To The Orthodontist

Patient Information

Date___/___/_____ Nickname _____

Name _____
First Last MI

Address _____

City_____ ST____ Zip _____

Birth Date ___/___/_____ Age:_____ M_____ F _____

School_____ Grade _____

Hobbies/Sports _____

Siblings_____

Health History

Y N Clenching / Grinding Teeth
Y N Lip sucking / Biting
Y N Constant Mouth-breathing
Y N Thumb / Finger Sucking
Y N Tongue Thrust
Y N Speech Problems
Y N Nail Biting
Y N Tonsils Removed

Any pain in the Jaw Joint or TMJ? N Y _____
Any Injuries to the Face, Mouth, or Teeth? Y N
Is your child currently under the care of a Physician? Y N
Physician Name_____ Phone# _____

Please list all medications your child is taking: _____
_____

Please list any allergies to medications / other: _____
_____

Responsible Party

Name _____
First Last MI

Relation_____ **Phone#** _____

Address _____

City_____ ST____ Zip_____

Cell#_____Emergency# _____

Birthdate____/____/_____ Marital Status _____

Employer_____ Wk# _____

2nd Guardian_____ Relation _____

Address_____City_____ _____

Zip_____ **Phone#**_____**Cell#**_____

Employer_____ Wk# _____

Y N Abnormal Bleeding
Y N High Blood Pressure
Y N Allergies to metals/latex
Y N Rheumatic / Scarlet Fever
Y N Asthma / Hay Fever
Y N Congenital Heart Defect
Y N Seizures/Epilepsy
Y N Taken the drug Phen-Fen
If yes, When_____
Y N Artificial Bones/Joints/Valves
Y N Handicaps / Disabilities
Y N Hospital Stays
Y N Hepatitis
Y N Kidney Problems
Y N Liver Problems
Y N Lupus
Y N Tuberculosis (TB)
Y N Diabetes
Y N HIV+ / AIDS
Y N Any Operations
Y N Heart Murmur
Y N Hemophilia
Y N Cancer
Y N ADD / ADHD

Please discuss any medical problems your child has: _____
_____
_____
_____

Dental Information

Is this your first visit to an orthodontist? _____

Dentist_____ Last Visit _____/_____/ _____

How did you hear about our office?_____

Do you have dental insurance? ___Y ___N

Insurance Co. Name_____

Policy Owner's Name _____

Policy Owners SS # _____BD___/___/ ____

2nd Insurance Co. Name _____

Policy Owners Name _____ _____

Policy Owners SS # _____BD__/___/_____

I understand that the information that I have given is true to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____
Signature of Parent or Guardian Date

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 to this office.

_____ _____
Signature of Parent or Guardian Date