

Welcome to our practice! We strive to make every child's visit pleasant and comfortable. To help us meet all of your child's healthcare needs, please fill out this form completely in ink.

Your Child

Child's Name _____
 Prefer to be called _____ Sex _____
 Birthdate _____ Age _____
 School _____ Hobbies _____
 List Brothers/Sisters with Age _____

Child's Home Address _____
 City _____ State _____ Zip _____
 Phone _____

Who is responsible for making appointments?

Name _____
 Cell Phone _____ Work Phone _____

Mother Mother Stepmother Guardian

Name _____
 Address _____
 Home Phone _____ Cell Phone _____
 Work Phone _____ Ext. _____
 Employer _____
 Occupation _____

Marital Status Single Married Divorced
 Widowed Separated

Primary Dental Insurance

Insured's Name _____
 Relationship _____
 Birthdate _____ SS# _____
 Employer _____
 Occupation _____
 Insurance Company _____
 Group # _____ Insurance ID _____
 Insurance Co. Address _____
 City _____ State _____ Zip _____
 Insurance Telephone # _____

Financial Arrangements

For your convenience, we offer the following methods of payment:
 Cash, Personal Check, Care Credit, Visa, MasterCard, Discover, and American Express

Responsible Party

Name _____
 Relationship _____
 Address _____
 City _____ State _____ Zip _____
 SS# _____
 Date of Birth _____

Whom may we thank for referring you?

Home Phone _____
 Ext. _____ Email _____

Father Father Stepfather Guardian

Name _____
 Address _____
 Home Phone _____ Cell Phone _____
 Work Phone _____ Ext. _____
 Employer _____
 Occupation _____

Marital Status Single Married Divorced
 Widowed Separated

Additional Dental Insurance

Insured's Name _____
 Relationship _____
 Birthdate _____ SS# _____
 Employer _____
 Occupation _____
 Insurance Company _____
 Group # _____ Insurance ID _____
 Insurance Co. Address _____
 City _____ State _____ Zip _____
 Insurance Telephone # _____





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

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 Dentist: _____

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 / materials that your child is allergic to:



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

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

Please list any medical problems that your child has / or has had:

Has your child ever experienced any of the following?

- | | |
|---------------------------------------|-----------------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

In case of Emergency Neighbor or Relative not living with you:

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.

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.

Signature Date