WELCOME - Child Orthodontic

To assist us in providing the most comprehensive care, please provide the following information.

PATIENT INFORMATION

Name: _____ Nickname: _____
First Middle Last

Date of Birth: _____/_____/ _____ Age: _____ Sex: _____ School: _____ Grade: _____

Emergency Contact: _____ Phone#: _____

How did you hear about our office? _____

MOTHER

Name: _____
First Middle Last

Home Address: _____

City: _____State: _____ Zip: _____

Home Phone #: (_____) _____Cell #: (_____) _____

Email: _____

Employed by: _____

Work Phone #: (_____) _____

Social Security #: _____DOB:_____

FATHER

Name: _____
First Middle Last

Home Address: _____

City: _____State: _____ Zip: _____

Home Phone #: (_____) _____Cell #: (_____) _____

Email: _____

Employed by: _____

Work Phone #: (_____) _____

Social Security #: _____DOB:_____

INSURANCE INFORMATION

Policy Holder: _____ Date of Birth: _____ Social Security #: _____

Member ID # : _____ Group #: _____

Employer Name and Address: _____

Relationship to Patient: _____

Name of Insurance Company: _____ Telephone # of Insurance Company: (_____) _____

Address to Send Dental Claims: _____

AUTHORIZATION

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of changes in medical status.

Child Consent:

I am the parent, guardian, or personal representative of _____. There are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above.

Insurance Assignment and Release:

I certify that my dependent is covered by insurance with _____. I assign directly to A Smile 4 U all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

A Smile 4U may use my child's health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Date

]PLEASE COMPLETE BOTH SIDES

PATIENT MEDICAL HISTORY

Patients Physician: _____ Phone #: _____

Date of last physical examination: _____ Are you currently under the care of a physician? Yes No

If yes, explain: _____

For Women: Are you taking birth control pills? Yes No / Are you pregnant? Yes No - Due Date: _____ / Are you nursing? Yes No

Please list current prescription medications:

_____

_____

Y N Have you ever taken (currently or previously) bone loss prevention medication such as Fosamax, Actonel, or Boniva?

Are you allergic to any of the following:

Y N Aspirin Y N Amoxicillin Y N Augmentin Y N Biaxin Y N Codeine Y N Dental Anesthetics
Y N Erythromycin Y N Ibuprofen Y N Keflex Y N Latex Y N Metals Y N Omnicef
Y N Penicillin Y N Sulfa Y N Tetracycline Y N Zithromax

Other if not listed: _____

Do you currently have or have you had the following:

Y N ADD/ADHD
Y N Alcohol/Drug Dependency
Y N Anemia
Y N Anorexia/Bulimia
Y N Artificial Joint(s) (hip/knee)
Y N Asthma
Y N Autism/Asbergers
Y N Bleeding Abnormally with Extraction
Y N Blood Disease
Y N Cardiac Pacemaker
Y N Cancer / Chemotherapy / Radiation Treatment
Y N Congenital Heart Defect
Y N Cough (Chronic)
Y N Cold Sores/Fever Blisters
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy or Seizures
Y N Fainting
Y N Headaches (Frequent)
Y N Hearing Concerns
Y N Heart Attack History
Y N Heart Disease/Angina
Y N Heart Murmur
Y N Heart Surgery
Y N Heart Valve Defect
Y N Hemophilia/Blood Transfusion
Y N Hepatitis (A, B, C) / Liver Disease
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Nervousness/Anxiety
Y N Pre-Medication (Antibiotic before Dental)
Y N Psychiatric Care
Y N Respiratory Disease
Y N Rheumatic/Scarlet Fever
Y N Chicken Pox/Shingles
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Sickle Cell Disease
Y N Sinusitis
Y N Smoke or use tobacco
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis

PATIENT DENTAL HISTORY

Do you currently have or have you had the following?

Y N Thumb or Finger Sucking (presently)
Y N Thumb or Finger Sucking (previously)
Y N Had Primary Teeth Removed
Y N Had Permanent Teeth Removed
Y N Speech Concerns
Y N Swallowing Concerns
Y N Injury to Face and/or Teeth
Y N Nighttime Teeth Grinding
Y N Clicking or Pain When Opening Jaws
Y N Headaches/Neck Aches
Y N Sore Muscles (neck/face)
Y N TMJ Symptoms

What are your chief concerns regarding orthodontic treatment:

_____

_____

Please describe reasons for considering orthodontic treatment:

_____

_____

Recent Dental Check-up/Cleaning
Date: _____ By Whom: _____

Previous Orthodontic Treatment
Date: _____ By Whom: _____

Previous Examination by an Orthodontist:
Date: _____ By Whom:
_____

DR. HAS REVIEWED THE PATIENT MEDICAL & DENTAL/ ORTHODONTIC HISTORY

DR'S INITIALS _____

DATE: _____