



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 establish a partnership with you and your child that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Male Female

Child's Name: _____
LAST FIRST MI

Nickname: _____

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: _____

Child's Home Address: _____
Apt. / Condo #

CITY STATE ZIP

Email: _____

4 Person Responsible For Account

Father (skip this section if information given below)

Mother (skip this section if information given below)

Other (complete this section):

Name: _____ Relation: _____

Billing Address: _____
Apt. / Condo #

CITY STATE ZIP

Work #: _____ Ext.: _____ Home #: _____

Employer: _____

Job Title: _____ Soc. Sec. #: _____

2 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? _____

General Dentist: _____

Date of Last Visit: _____

5 Orthodontic Insurance*

* Note: The information below is given for purposes of helping you receive your insurance benefits. We will help you fully utilize your coverage as much as possible. However, the patient or parent is ultimately responsible for payment of services rendered.

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID#: _____

Policy Owner's Employer: _____

(Continued on Back) →

3 Mother's Information Step Mother? Guardian?

Name: _____

Work #: _____ Ext.: _____ Home #: _____

Other #: _____ Pager Cell Ph. Other

Employer: _____

Job Title: _____

Soc. Sec. #: (if responsible for account) _____

Father's Information Step Father? Guardian?

Name: _____

Work #: _____ Ext.: _____ Home #: _____

Other #: _____ Pager Cell Ph. Other

Employer: _____

Job Title: _____

Soc. Sec. #: (if responsible for account) _____

6 Dental / Health History

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

Have there been any injuries to the face, mouth, or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Does your child take antibiotics or other medicines before dental appointments? 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

Child's physician: _____

Phone #: _____ Date Last Visit _____

Is your child currently under a physician's care? Yes No

Has puberty begun? Yes No

Approx. date menstruation begun (Girls): _____ N/a

Please list all drugs that your child is currently taking: _____

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

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

Y N Abnormal Bleeding	Y N Diabetes
Y N Allergies to any drugs	Y N Handicaps / Disabilities
Y N Allergy to Latex / Metals	Y N Hearing Impairment
Y N Allergy to Plastic	Y N Heart Murmur
Y N Asthma	Y N Hemophilia
Y N Cancer	Y N Hepatitis
Y N Congenital Heart Defect	Y N HIV / AIDS
Y N Convulsions / Epilepsy	Y N Kidney / Liver Problems
Y N Tuberculosis (TB)	Y N Rheumatic / Scarlet Fever

Please discuss any medical problems your child has had:

8 Does / did your child have any of the following habits?

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

Neighbor or relative not living with you.

Name: _____ Phone _____

Address: _____

_____ CITY STATE ZIP

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

This office reserves the right to verify the credit status of patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of parent or guardian _____ Date _____

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

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 or deductibles that my insurance does not cover.

Signature of parent or guardian _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA