CONFIDENTIAL

SmartSmiles Orthodontics - Engineered Smiles by Dr. Foch M. Smart
315 Ray Thorington Rd. • Montgomery, AL 36117 • 334 . 271 . 2345 • www.SmartSmiles.com

SmartSmiles Orthodontics, PC

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

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: _____

Email:_____
(only if you would like email appointment reminders)

Cell #: _____ Cell Ph. Company: _____
(only if you would like text message appointment reminders)

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) _____

4 Person Responsible For Account

(skip questions already answered below)

Name:_____ Relation: _____

Address: _____ ☐Own ☐Rent

City _____ State_____ Zip _____

How long at address? _____

Soc. Sec. #:_____ Birthdate: ____/____/_____

Home # _____ Cell #_____

Work #: _____ Ext.: _____

Occupation: _____

Employer: _____ How Long? _____

5 Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Policy #: _____

Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate:____/___/___ SS#: _____

Policy Owner's Employer: _____

(Continued on Back) →

Note: We respect your privacy. Questions about home ownership, length of employment, etc. are required only if orthodontic treatment will be financed through this office.

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

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.

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

_____

Signature of parent or guardian Date

I hereby authorize SmartSmiles Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

_____

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