FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD

Today's date: _____ DOB: _____

Child's Name: AGE: _____

Last First Mi

Nickname: _____ Male Female

School: _____ Grade: _____

Home #: _____

SS #: _____

Child's Home Address:

Apt#

City State Zip

Siblings:

Name _____ Age _____

Name _____ Age _____

2.) WHO IS WITH THE CHILD TODAY?

Name: _____

Relation: _____

Do you have legal custody of this child?

YES NO

Who may we thank for referring you? _____

Other family members seen by us:

Previous/Present Dentist: _____

Street: _____

Phone #: _____ Last Visit: _____

Parent's Marital Status: _____

(single, married, divorced)

3.) MOTHER'S INFORMATION:

Name: _____

WK#: _____ Ext. ____ HM#: _____

Employer: _____

DL#: _____

SS#: _____

FATHER'S INFORMATION:

Name: _____

WK#: _____ Ext. ____ HM#: _____

Employer: _____

DL#: _____

SS#: _____

4.) RESPONSIBLE PARTY INFO:

Name: _____

Billing address: _____

City State Zip

WK#: _____ Ext. ____ HM#: _____

Employer: _____

DL#: _____

SS#: _____

Who is responsible for making appts?

Name: _____

WK#: _____ Ext. ____ HM#: _____

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

6) Why did you bring the child to the Orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work? Y N
Is the child's water fluoridated? Y N
Is the child taking fluoridated supplements?
Y N
Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
Y N
Does the child brush teeth daily? Y N
Floss their teeth daily? Y N
Child's Physician: _____
Phone#: _____ Last visit: _____
Is the child currently under the care of a physician? Y N
Please describe the child's health:
GOOD FAIR POOR

Please list all drugs the child is currently taking: _____

Please list all drugs the child is allergic to:

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

Y N	Heart Murm.	Y N	Congenital Heart Def.
Y N	Cancer	Y N	Convulsions/Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheum. Fev.	Y N	Hearing Impairment
Y N	HIV+/AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any Stays in Hospital
Y N	Asthma	Y N	Kidney/Liver Problems
Y N	Hepatitis	Y N	Handicaps/Disabilities
Y N	Tuberculosis	Y N	Allergies to Any Drugs
Y N	Prosthesis	Y N	History of Scarlet Fever

Please discuss any serious medical problems that the child has had: _____

8) Does the child have any of the following habits?

Y N Thumb sucking / Finger sucking
Y N Lip sucking / biting
Y N Nail Biting
Y N Nursing Bottle Habits

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

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent/guardian Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.
Initials: _____ Date: _____

Doctor's comments: _____

Medical History Update:
1. Date: _____ Signature: _____
Comments: _____

2. Date: _____ Signature: _____
Comments: _____

FOR ADULTS: WELCOME TO OUR PRACTICE

1.) ABOUT YOU

Today's date: _____ DOB: _____

Name: _____ AGE: _____

Last First Mi (Mr. Mrs. Ms.)

I preferred to be called: _____

Home #: _____

Work #: _____

SS #: _____

DL #: _____

Home Address:

Apt#

City State Zip

2.) ABOUT YOUR EMPLOYER:

Name: _____

Address: _____

How long have you worked there? _____

Occupation: _____

When & Where are the best times to reach you? _____

Other family members seen by us:

Who may we THANK for referring you? _____

3.) SPOUSE INFORMATION:

Name: _____

Employer: _____

WK#: _____

DL#: _____

SS#: _____

DOB:

DENTAL INFORMATION:

Previous/Present Dentist: _____

Street: _____

Phone: _____ **Last visit:** _____

4.) RESPONSIBLE PARTY INFO:

Name: _____

Billing address: _____

City State Zip

WK#: Ext. HM#:

Employer: _____

DL#: _____

SS#: _____

Emergency Contact:

Name: _____ Relation: _____

WK#: Ext. HM#:

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

6) DENTAL HISTORY

Why have you come to the orthodontist today? _____

Are you currently in pain? Y N

Your current dental health is:

Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? _____

A day do you brush? _____

Types of bristles? Hard Medium Soft

7) MEDICAL HISTORY

Do you have a personal physician? Y N

Name: _____

Phone: _____ Last visit: _____

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: _____

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

8) Have you ever had any of the following diseases or medical problems?

Y N	Prothesis	Y N	History of Scarlet Fever
Y N	Heart attack	Y N	Congenital Heart Def.
Y N	Cancer	Y N	Convulsions/Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheum. Fev.	Y N	Artificial Valves
Y N	HIV+/AIDS	Y N	Heart surgery/Pacmkr.
Y N	Hemophilia	Y N	Any Stays in Hospital
Y N	Asthma	Y N	Kidney/Liver Problems
Y N	Hepatitis	Y N	Mitral Valve Prolapse
Y N	Tuberculosis	Y N	Artificial bones/joints
Y N	Shingles	Y N	Sev./Freq. headaches
Y N	Fever blister	Y N	Hi/Lo blood pressure
Y N	Venereal dis.	Y N	Drug/Alcohol Abuse
Y N	Ulcers/Colitis	Y N	Blood Transfusion
Y N	Heart Murm.	Y N	Anemia/Radiation tmt.
Y N	Emphysema	Y N	Glaucoma
Y N	Sinus Probs.	Y N	Difficulty Breathing?
Y N	Other:		

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin
Y N	Codeine	Y N	Dental Anesthetics
Y N	Latex	Y N	Tetracycline
Y N	Penicillin	Y N	Other:

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9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

_____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY — OFFICE USE ONLY — OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

_____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____