

**PATIENT INFORMATION**

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M F SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ACTIVITIES/HOBBIES \_\_\_\_\_ AGES OF BROTHERS AND SISTERS ( ) ( ) ( ) ( )

LIST ANY FAMILY MEMBERS WHO HAVE RECEIVED TREATMENT AT THIS OFFICE: \_\_\_\_\_

DENTIST \_\_\_\_\_ WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**PRIMARY PARENTAL/RESPONSIBLE PARTY INFORMATION**

RELATIONSHIP TO PATIENT: \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
(if different from patient)

HOW LONG AT THIS ADDRESS? \_\_\_\_\_ PREVIOUS ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_

CURRENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

**SECONDARY PARENTAL/RESPONSIBLE PARTY INFORMATION**

RELATIONSHIP TO PATIENT: \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
(if different from patient)

HOW LONG AT THIS ADDRESS? \_\_\_\_\_ PREVIOUS ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_

CURRENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

INS. CO NAME (PRIMARY) \_\_\_\_\_

INS. CO NAME (SECONDARY) \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_

INSURANCE IDENTIFICATION NO. \_\_\_\_\_

INSURANCE IDENTIFICATION NO. \_\_\_\_\_

POLICY HOLDER BIRTHDATE \_\_\_\_\_

POLICY HOLDER BIRTHDATE \_\_\_\_\_

POLICY HOLDER EMPLOYER \_\_\_\_\_

POLICY HOLDER EMPLOYER \_\_\_\_\_

**HAVE YOU CHECKED WITH YOUR CARRIER REGARDING YOUR ORTHODONTIC BENEFITS?**  YES  NO

# Dental History

Why are you interested in orthodontic treatment for your child? \_\_\_\_\_

Has your child ever been evaluated for orthodontic treatment?  Y  N When? \_\_\_\_\_ By whom? \_\_\_\_\_

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

If yes, please describe: \_\_\_\_\_

Check (✓) if your child has had any of the following:

- Mouth or chin injury  Y  N
- Dental or facial pain  Y  N
- Jaw clicking, locking or noise  Y  N
- Mouth breather  Awake  Asleep
- Oral habits affecting the mouth or teeth:  Nail biting  Thumb Sucker  Other: \_\_\_\_\_

Other information about your dental health or previous treatment \_\_\_\_\_

# Medical History

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Has your child had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Is your child currently under physician care?  Y  N If yes, describe: \_\_\_\_\_

Has your child ever had a blood transfusion?  Y  N If yes, give approximate dates: \_\_\_\_\_

Have the child's adenoids or tonsils been removed?  Y  N

Check (✓) if your child has had any of the following:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Cough, persistent     | <input type="checkbox"/> Hearing impairment              | <input type="checkbox"/> Sensory Disorder               |
| <input type="checkbox"/> AIDS/HIV Positive              | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Hemophilia/abnormal bleeding    | <input type="checkbox"/> Sinus problems                 |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Kidney disease or malfunction   | <input type="checkbox"/> Skin rash                      |
| <input type="checkbox"/> Asperger's, Autism Spectrum    | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Liver disease                   | <input type="checkbox"/> Spina Bifida                   |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Food allergies        | <input type="checkbox"/> Material allergies              | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Atopic (allergy prone)         | <input type="checkbox"/> Headaches             | ( <b>latex</b> , wool, metal, chemicals)                 | <input type="checkbox"/> Tonsillitis                    |
| <input type="checkbox"/> Behavioral or Emotional Issues | <input type="checkbox"/> Heart problems/murmur | <input type="checkbox"/> Mental or Physical Disabilities | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Blood disease                  | Describe _____                                 | <input type="checkbox"/> Respiratory disease             | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Cancer                         | Premed? _____                                  | <input type="checkbox"/> Rheumatic/Scarlet fever         |   |

Please describe if you answered yes to any of the above: \_\_\_\_\_

List medications you are taking, if any: \_\_\_\_\_ List drug allergies, if any: \_\_\_\_\_

# Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The policy in our office is that the parent who requests treatment is responsible for all fees of services rendered.  
When appropriate - credit information will be obtained.