WELCOME TO OUR PRACTICE!

Please fill out completely and bring with you to the Consultation Appointment!
Our office advises that your child should have their teeth cleaned prior to your scheduled consultation!

Today's Date:____________ Child's Name:____
First Middle Last

Nickname:________________ School:_________________ Grade:_______ DOB:__________ Age:________

Home Address:____
City State Zip
Other family seen by us:____

MALE OR FEMALE Home#:__________________________________

Mother's Information

Name:__________________________DOB:________

Address:_____________________________________
(If different than above)

____
City State Zip

Home#:_______________ Cell#:_________________

Work#:___________________

Employer:____________________________________

DL#:_________________
SS#:___________________

Can we contact you via Email? Y or N

Email Address:________________________________

Parent's Marital Status:_________________________

Father's Information

Name:___________________________DOB:_________

Address:____________________________________
(If different than above)

____
City State Zip

Home#:________________ Cell#:__________________

Work#:______________________

Employer:_____________________________________
_

DL#___________________ SS#:__________________

Can we contact you via Email? Y or N

Email Address:__________________________________

Parent's Marital Status:___________________________

RESPONSIBLE PARTY INFORMATION

This person will sign the contract and be completely responsible for all aspects of the patient's account, therefore account information will not be discussed with anyone else without prior written authorization!

Name:_____________________________ Relation:___________________ Home#:_____________________

Billing
Address:____
City State Zip
Dental Insurance Company: ___________________________________ Orthodontic Coverage? Y or N
(If you are unsure of orthodontic coverage we will
Employer:______________________________________ gladly check for you)

EMERGENCY CONTACT

Name:______________________________________ Relation:________________________

Home:_______________________ Work#:____________________Ext:_________ Cell#:_________________
DL:_________________________ SS#:____________________________ Cell#:______________________

WHO IS WITH PATIENT TODAY?

Name:_______________________________ Do you have legal custody of this child? Y or N

Relation:_______________________ Who may we thank for referring you?_____________________________

Please bring your dental insurance card with you so that we can verify your benefits at the initial visit!

DENTIST INFORMATION

Dentist:____

_

Address:____

____

City State Zip

Office#:____________________ Last Visit:__________

DENTAL HISTORY

Orthodontic Concerns:___________________________

Has the child ever had any pain or tenderness in the jaw joint? Yes or No

Has the child ever had a serious/difficult problem associated with dental work? Yes or No

Is the child taking fluoridated supplements? Yes or No
How often does the child brush/floss their teeth?

____

Child's Physician:_______________________________

Phone#:____________________ Last Visit:___________

Is the child currently under care of a physician? Yes or No
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:____________

____

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

HAS THIS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Y N Heart Murm.
Y N Congenital Heart Def.
Y N Artificial Valves
Y N Heart Surg/Pacmkr.
Y N Mitral Valve Prolapse
Y N Hi/Lo Blood Press.
Y N Blood Transfusion
Y N Hemophilia
Y N HIV+/AIDS
Y N Hepatitis
Y N Abnormal Bleeding
Y N Anemia/Radiation Tmt.
Y N Cancer
Y N Diabetes
Y N Prosthesis
Y N Artificial Bones/Joints
Y N Kidney/Liver Probs
Y N Convulsions/Epilepsy
Y N Sev./Freq. Headaches
Y N Difficulty Breathing
Y N Asthma
Y N Tuberculosis
Y N Rheum. Fever
Y N History Scarlet Fever
Y N Shingles
Y N Fever Blisters
Y N Sinus Probs.
Y N Glaucoma
Y N Hearing Impairment
Y N Any Operations
Y N Any Hospital Stays
Y N Handicaps/ Disabilities
Y N Other:_______

____

____

Please discuss any serious medical problems the child has/had:____________________________________

_

____

____

DOES THIS CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Thumb/Finger/Lip Sucking
Y N Biting
Y N Nail Biting
Y N Nursing Bottle Habits

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

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED OR OTHERWISE STATED IN CONTRACT.

OFFICE USE ONLY***OFFICE USE ONLY***OFFICE USE ONLY

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

Initials:_________ Date:__________ Doctor's Comments:______________________________________