

# WELCOME



*We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information

Name \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_  
999-999-9999

Whom may we thank for referring you to our office \_\_\_\_\_

## Parents Information

### Father

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### Mother

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Insurance Information

Policy Owner's Name \_\_\_\_\_ Policy Owner's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. (plan, local, or policy) \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

Do You have Dual Coverage \_\_\_\_\_

## General Information

School \_\_\_\_\_

Brothers/Sisters  
(include ages)

Hobbies

## Medical History

Medical Physician? \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Is the child currently under the care of a physician? Yes No If Yes, explain \_\_\_\_\_

Has puberty begun? Yes No Has menstruation (period) begun? Yes No N/A

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has the patient ever been evaluated for orthodontic treatment? Yes No

Have the patient's tonsils or adenoids been removed? Yes No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to : (select all that apply) Teeth Mouth Chin

Has the patient ever had any of the following habits?

Lip Sucking/Biting

Nail biting

Prolonged Bottle/Pacifier

Clenching/Grinding Teeth

Mouth Breather

Tongue Thrusting

Thumb/ Finger Sucking

Does the patient have speech problems? Yes No If Yes, explain \_\_\_\_\_

Is the child allergic to any of the following?

Aspirin Erythromycin

Codeine Penicillin

Tetracycline Latex

Any Metals/Plastics

Other Allergies/Sensitivities:  
\_\_\_\_\_

List all drugs the Patient is currently taking

List any serious medical condition(s) treated

## Signature

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

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_