PATIENT INFORMATION
CHILD

Date _____

CHILD'S INFORMATION

Name_____
Last First MI

Birthdate_____ Age_____
SSN_____-_____-_____ ☐ Male ☐ Female
Child lives with ☐ Mother ☐ Father ☐ Both
General Dentist's Name_____
Phone (_____)_____-_____
Date of Last Visit_____

PARENT'S INFORMATION

☐ Mother ☐ Father ☐ Guardian ☐ Other_____
Name_____
Last First MI
Address_____
Street Apt#

_____
City State Zip

Birthdate_____ SSN_____-_____-_____
DL#_____
Email Address_____
Home Phone (_____)_____-_____
Cell Phone (_____)_____-_____
Employer_____
Occupation_____ How Long_____
Work Phone (_____)_____-_____ ext_____
Responsible for the account? ☐ Yes ☐ No

☐ Mother ☐ Father ☐ Guardian ☐ Other_____
Name_____
Last First MI
Address_____
Street Apt#

_____
City State Zip

Birthdate_____ SSN_____-_____-_____
DL#_____
Email Address_____
Home Phone (_____)_____-_____
Cell Phone (_____)_____-_____
Employer_____
Occupation_____ How Long_____
Work Phone (_____)_____-_____ ext_____
Responsible for the account? ☐ Yes ☐ No

INSURANCE INFORMATION

DOES YOUR CHILD HAVE ORTHODONTIC COVERAGE? ☐ Yes ☐ No

Insurance Co. Name_____
Insurance Co. Address_____
Insurance Co. Phone (_____)_____-_____
Group/Plan#_____
Name of Primary Insured_____
Relationship to Patient_____
Primary's Employer_____
Primary's Birthdate_____
Primary's SSN _____-_____-_____

IS THERE SECONDARY ORTHODONTIC COVERAGE? ☐ Yes ☐ No

Insurance Co. Name_____
Insurance Co. Address_____
Insurance Co. Phone (_____)_____-_____
Group/Plan#_____
Name of Primary Insured_____
Relationship to Patient_____
Primary's Employer_____
Primary's Birthdate_____
Primary's SSN _____-_____-_____

Whom may we thank for referring you to our office?

_____

AUTHORIZATION

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS, PARENTS, AND/OR RESPONSIBLE PARTIES PRIOR TO EXTENDING CREDIT FOR TREATMENT FEES AND MAY, AT ITS DISCRETION, USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES.

INSURANCE IS BILLED AS A COURTESY. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED, INCLUDING ANY CO-PAYMENTS AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER.

I HEREBY AUTHORIZE THE OFFICE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ASSIGN DIRECTLY TO THE DOCTOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

_____
Signature Date

PLEASE COMPLETE THE INFORMATION ON THE BACK

PATIENT HEALTH QUESTIONNAIRE

Dental Information

Main Concerns

	Mild	Moderate	Severe
Facial Pain	☐	☐	☐
Gum Problems	☐	☐	☐
Jaw Dysfunction	☐	☐	☐
Neck Pain	☐	☐	☐
Bad Bite	☐	☐	☐
Crowded Teeth	☐	☐	☐
Impacted Tooth/Teeth	☐	☐	☐
Missing Tooth/Teeth	☐	☐	☐
Protrusion of Teeth	☐	☐	☐
Spaces	☐	☐	☐
Underbite	☐	☐	☐
Dentist Recommended	☐	☐	☐

Other_____

Has your child ever had:

Yes	No		Yes	No	
☐	☐	Chin Injury	☐	☐	Mouth Injury
☐	☐	Clicking in the Jaw Joint	☐	☐	Pain in Jaw Joint
☐	☐	Difficulty Chewing	☐	☐	Smoking
☐	☐	Difficulty Swallowing	☐	☐	Snoring
☐	☐	Finger Sucking	☐	☐	Sore Teeth
☐	☐	Grinding Teeth	☐	☐	Speech Problems
☐	☐	Gums Bleeding/Sore	☐	☐	Tooth/Teeth Injury
☐	☐	Headaches	☐	☐	Thumb Sucking
☐	☐	Lip Biting	☐	☐	Tongue Thrusting
☐	☐	Mouth Breathing	☐	☐	Tonsillitis

☐ Other_____

How often does your child have regular dental checkups?

☐ Twice a year
☐ Once a year
☐ Only if necessary
☐ Never

How does your child feel about orthodontic treatment?

☐ Eager for treatment
☐ Willing if necessary
☐ Dreading but agree
☐ Unwilling

Orthodontic consultation was prompted by:

☐ Parent
☐ Dentist
☐ Other_____

Has your child ever had a previous orthodontic consultation or treatment?

☐ Yes ☐ No
Name of the Dr._____

Has your child ever had any unusual dental experiences?

☐ Yes ☐ No

Medical Information

Has your child ever had or currently has any of the following:

Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Arteriosclerosis	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Female Problems
☐	☐	Autoimmune Disorder	☐	☐	Hearing Disorders
☐	☐	Blood Disease	☐	☐	Heart Disease
☐	☐	High Blood Pressure	☐	☐	Hepatitis
☐	☐	Low Blood Pressure	☐	☐	HIV/AIDS/ARC (please circle)
☐	☐	Bone Disorders	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Ringing of Ears
☐	☐	Dizziness	☐	☐	Sleep Disturbance
☐	☐	Emotional Problems	☐	☐	Trauma (to face, teeth, jaw, or head)

Have you ever been told to pre-medicate before dental procedures?

☐ Yes ☐ No

☐ Other_____

Is your child currently taking any medications?

☐ Yes ☐ No
If so please list them:_____

_____

Is your child allergic to any of the following:

☐ Antibiotics (specify) _____
☐ Dairy Products
☐ Food Dyes
☐ Pain Pills (specify) _____
☐ Wheat Products
☐ Latex
☐ Metals_____
☐ Other_____

Has puberty begun?	☐ Yes	☐ No
Has menstruation begun?	☐ Yes	☐ No
Are the child's immunizations current?	☐ Yes	☐ No

How would you rate your child's overall health?

☐ Good ☐ Fair ☐ Poor

Are there any other medical, dental, surgical, or psychological problems not covered?

☐ Yes ☐ No
If so please list them:_____

The information given above is true and correct to the best of my knowledge. I understand that the information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status.

_____
Signature Date