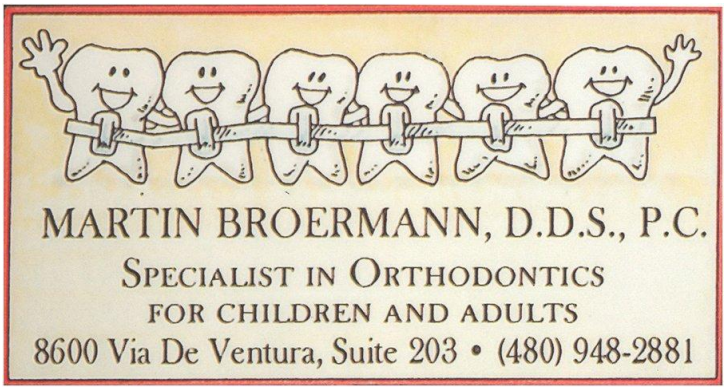

Our goal is to provide personalized orthodontic treatment in a caring environment.

We look forward to working with your child to achieve an optimum result!

Tell us about Your child

Today's date___/___/___

Patient's Name_____

Birth date ___/___/___ Age_____ Male Female

Nickname_____ School_____

Hobbies_____ Grade_____

Child's Home Phone (_____)_____

Child's Home Address_____

_____

Who is bringing your Child Today?

Name_____ Relation_____

Do you have legal custody of this child? Yes No

Please let us know who referred you to us_____

Please list brothers/sisters with age_____

_____

General Dentist_____

Last Visit_____

Parent's Marital status single married divorced widowed

Separated partnered

Mother's information stepmother guardian

Name_____ Birth date___/___/___

Work # (_____)_____ext____ Home # (____)_____

Cell # (_____)_____SS#_____

Employer_____ Job Title_____

Father's Information stepfather guardian

Name_____ Birth date ___/___/___

Work # (_____)_____ext ____Home # (_____)_____

Employer_____ Job Title_____

Cell # (_____)_____SS#_____

Person Responsible for Account

Name_____ Relation_____

Billing Address_____

_____

Home # (_____)_____Cell # (_____)_____

Employer_____ _____

Work # (_____)_____ext____SS # _____

Primary Orthodontic Insurance

Orthodontic coverage Yes No

If no orthodontic coverage skip this section

Insurance Co. name_____

Insurance Co Phone # (_____)_____Group #_____

Policy Owner's name_____

Relation to Patient_____

Policy Owner's Birthday___/___/_____ ID #_____

Policy Owner's Employer_____

Secondary Orthodontic Insurance

Orthodontic coverage Yes No

Insurance Co. name_____

Insurance Co Phone # (_____)_____Group # _____

Policy Owner's name_____

Relation to Patient_____

Policy Owner's Birthday___/___/_____ ID #_____

Policy Owner's Employer_____

Please fill out the health history on the next page

Medical History

Your child's current physical health is good fair poor

Is your child currently under the care of a physician? Y N

Please explain_____

Is your child taking any prescription/over the counter drugs? Y N

Please List _____

Has your child ever had any of the following diseases or medical conditions? (please circle if yes)

Abnormal bleeding	Hemophilia
ADD/ADHD	Hepatitis
Anemia	High/Low Blood Pressure
Asthma/Arthritis	HIV/AIDS
Blood Transfusion	Hospitalized
Cancer/Chemotharapy	Operations
Congenital Heart Defect	Rheumatic/Scarlet Fever
Diabetes	Severe/Frequent Headaches
Difficulty Breathing	Sickle Cell Disease/Traits
Emphysema	Sinus Problems
Epsilepsy/Seizures/Fainting	Tuberculosis
Fever Blisters/Herpes	
Heart Murmur	
Heart Surgery	

Please list any serious medical condition(s) your child has ever had

_____

Please circle those your chid is allergic to

Aspirin	Dental Anesthetics	Penicillin
Metals	Erythromycin	Tetracycline
Codiene	Latex	Other

Please list other drugs or materials your child is allergic to_____

_____

What major concerns do you/your child want to address with orthodontic treatment?

_____

_____

Has your child ever had/been evaluated for orthodontic treatment? Y N

Has your child ever had problems with previous dental work? Y N

Has your child ever had any injury to their Face Mouth Chin Teeth

Please comment _____

Has your child ever had any problems with jaw joints/TMJ/TMD? Y N

Overall all their present dental health is : Good Fair Poor

Does your child have any missing teeth? Y N

Does your child have any extra teeth? Y N

Do your child's gums ever bleed? Y N

Does your child clench or grind their teeth? Y N

Has your child ever been told they are a mouth breather? Y N

Has your child ever been told they have tongue thrust? Y N

The information I have given today is correct to the best of my knowledge. I understand this information will be kept strictly confidential . I also understand that it is my responsibility to inform this office of any change in my child's medical/health history. I also authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent.

_____

signature date