WELCOME!

We would like to welcome you and your child to our office. Our goal is to help your child achieve a beautiful smile and while reaching and maintaining maximum oral health in a warm, courteous, safe and caring environment. Please fill out these forms completely.

Child's Name:_____ Nickname:_____

Birthdate:_____ Child's Age:_____

School:_____ Grade:_____

Child's Home Phone #:_____ Child's Cell Phone #_____

Child's Home Address:_____

_____

City State Zip Code

Mother's Full Name_____

Mother's Address (if different than child)_____

Cell #_____ Cell Provider_____ Email_____

Home#_____ Employer_____ Work#_____

Father's Full Name_____

Father's Address (if different than child)_____

Cell #_____ Home #_____

Employer_____ Work #_____

How may we best contact you to make appointments for your child?_____

Name of person(s) financially responsible for account:_____

Address (if different than child)_____

_____

Emergency Contact other than Parent(s) in case we are unable to reach a parent

Name_____ Relationship to child_____

Phone #_____

Does the child have any siblings?

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Child's Dentist_____ Physician_____

Whom may we thank for referring you?_____

Medical History

Has the child ever had the following medical problems?

Y N	Latex Sensitive	Y N	Precocious puberty
Y N	Allergies to drugs, substances	Y N	Delayed Physical Growth and Maturation
Y N	Allergies	Y N	Hormone Therapy for growth related issues
Y N	Heart Murmur	Y N	Congenital Heart Defect
Y N	Cancer	Y N	Convulsions/Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheumatic Fever	Y N	Hearing Impairment
Y N	HIV+/AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any stays in a hospital
Y N	Asthma, Airway or Breathing Problems	Y N	Kidney/Liver Problems
Y N	Hepatitis	Y N	Handicaps/Disabilities
Y N	TB/Lung Disorders	Y N	Cold Sores/Fever Blisters
Y N	Blood Transfusion	Y N	Venereal Disease
Y N	Mitral Valve Prolapse	Y N	Diet (special, restricted)
Y N	Sickle Cell Disease	Y N	Artificial Joints (hip,etc.)
Y N	Ulcers/Stomach Disorders	Y N	Thyroid Problems
Y N	Chemotherapy, Radiation Treatment	Y N	Tumors
Y N	Nervous/Anxious	Y N	ADD, ADHD, PDD (circle one)
Y N	Austism, Asperger's Syndrome (circle one)	Y N	Fainting or Dizzy Spells
Y N	Sleep Apnea		

Please explain any medical problems that the child may have:_____

_____

Physical Development (please circle one): Early Late On Time
Percentile Height_____Percentile Weight_____

Adenoids or tonsils been removed? Y N

Boys - Voice Change Y N If yes, when did it change?_____

Girls – Onset of Menstruation Y N If yes, date of onset_____

Is the child currently under the care of a physician? Y N If yes, for what condition?_____

Please list all drugs that the child is currently taking and the reason for medication:_____

_____

Please list all drugs/substances that the child is allergic to:_____

_____

Dental History

Has the child had any previous orthodontic consultations or had orthodontic treatment? Y N

Why did you bring the child to the orthodontist today?_____

_____

Date of last dental visit?_____ Full x-rays_____

Has the child ever had serious/difficult problems associated with previous dental work? Y N
Has the child experienced early or late tooth eruption?_____
Play any musical wind instrument? Y N

Has the child ever had?

Y N Oral Surgery
Y N Serious Injury (mouth/head)
Y N Periodontal treatment

Has the child ever experienced?

Y N	Difficulty in chewing	Y N	Tired Jaws
Y N	Pain (joint, ear, face)	Y N	Problem opening, closing mouth
Y N	Headaches	Y N	Clicking or popping of jaw

Does the child have any of the following habits?

Y N	Tongue Thrust	Y N	Lip Biting
Y N	Thumb/Finger sucking	Y N	Nail/Pencil biting
Y N	Tooth Grinding	Y N	Nursing Bottle Habits
Y N	Mouth Breather		

As a courtesy and service to our patients we will provide a "super bill" that you may submit with your claim form for reimbursement from your insurance company. We do not accept assignment of benefits from the insurance companies.

It is important that your child attend their appointments. Please understand that a last minute cancellation or "no show" does not allow us enough time to accommodate another patient. Because the time we allot for your child is valuable, kindly give our office 24 hours notice if you must cancel your child's appointment. We reserve the right to charge a $150.00 for every 30 minutes for any appointment not cancelled within 24 hours.

I understand that I am responsible for all costs of orthodontic treatment and that in the event of a default of one of the responsible parties/parents, I am entirely responsible for all costs of orthodontic treatment and will pay them in a timely manner.

Signature of Responsible Person(s)

_____Date_____

_____Date_____

Please initial to acknowledge that you have received the Notice of Privacy Practices_____