smile more
ORTHODONTICS
www.smilemoreortho.com

1. ABOUT YOUR CHILD

Today's Date _____ Date of Birth _____
Child's Name Age _____

_____
Last First MI
I prefer to be called _____ Male/Female
School _____
Home # _____
Social Security # _____
Child's Home Address

_____
Apt. #

_____
City State Zip

2. WHO IS WITH THE CHILD TODAY?

Name _____
Relation _____
Do you have legal custody of this child? Yes No
How did you hear about our office?

_____
Other family members seen by us:

_____

_____
Present Dentist _____
Street _____
Phone # _____ Last Visit _____
Parent's Marital Status: Single Married Divorced

3. MOTHER'S INFORMATION

Name _____
Employer _____
Work # _____ Cell # _____
Home # _____ Date of Birth _____
Social Security # _____
Email Address _____

FATHER'S INFORMATION

Name _____
Employer _____
Work # _____ Cell # _____
Home # _____ Date of Birth _____
Social Security # _____
Email Address _____

4. RESPONSIBLE PARTY INFO

Name _____
Billing Address _____

_____
City State Zip
Home # _____
Cell # _____
Employer _____
Work # _____
Date of Birth _____
Social Security # _____
Email Address _____

5. PRIMARY DENTAL INSURANCE

Ins. Name _____
Ins. Address _____
Insurance Co. Phone # _____
Group/Policy # _____

_____
Insured's Name _____
Relationship to Patient _____
Insured's DOB _____
Insured's Employer _____
Social Security # _____
Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name _____
Ins. Address _____
Insurance Co. Phone # _____
Group/Policy # _____

_____
Insured's Name _____
Relationship to Patient _____
Insured's DOB _____
Insured's Employer _____
Social Security # _____
Orthodontic Coverage: YES NO

6. Why did you bring the child to the Orthodontist today?

Main Concern: _____

_____

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Does the child brush teeth daily? Y N

Floss their teeth daily? Y N

Child's Physician

Phone # _____Last Visit _____

Is the child currently under the care of a physician?

Y N Explain: _____

_____

_____

Please describe the child's health:

Good Fair Poor

Please list all the drugs the child is currently taking:

_____

_____

_____

Please list all the drugs the child is allergic to:

_____

_____

_____

_____

7. Has the child ever had any of the following medical problems?

Y N Heart Murmur	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fever	Y N Hearing Impairment
Y N HIV+/AIDS	Y N Any Operations
Y N Hemophilia	Y N Any Stays in Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Handicaps/Disabilities
Y N Tuberculosis	Y N Allergies to Any Drugs
Y N Prosthesis	Y N History of Scarlet Fever

Please discuss if you answered "Yes" to any of the above or any other serious medical problems that the child has had: _____

_____

_____

8. Does the child have any of the following habits?

Y N Thumb/Finger Sucking

Y N Lip Sucking/Biting

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

9. 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 _____

The Parent/Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.