

# 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.**