WELCOME

1 About Your Child

Today's Date: ____ /____ /____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____ /____ /____ Age: _____

Child's Home Phone #: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Has Dr. Jen treated any family members? ❑ Yes ❑ No

If yes, who_____

How did you hear about us? _____

2 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

How many Brothers/Sisters? _____ Age(s): ____ ____ ____

Mother's Name: _____

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____
HOME PHONE # WORK PHONE # EXT

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH EMAIL ADDRESS

Employer:_____ How Long? _____

Father's Name: _____

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____
HOME PHONE # WORK PHONE # EXT

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH EMAIL ADDRESS

Employer:_____ How Long? _____

3 Account/Insurance Information

Primary Dental Insurance

Ins. Co. Name: _____

Phone#: _____

Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ /____ /____

Insured's SS#: _____ - _____ - _____

Insured's Employer: _____

Does policy cover Orthodontics? ❑ Yes ❑ No

Person ultimately responsible for account

Name: _____

Relation: _____

Work Phone #: (_____) _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is patient's Medical Doctor or Pediatrician?

_____

Medical Doctor's Phone #: (_____) _____

Please Continue On Back

5 Patient's Dental Information

Please indicate any of the following problems:

❑ Injuries to teeth
❑ Thumb/finger sucking
❑ Clench/grind teeth
❑ Jaw Pain/pain around ear
❑ Gum surgery
❑ Injuries to face
❑ Wisdom teeth removed
❑ Jaw pops when chewing
❑ Headaches every day
❑ Wore braces previously

Dentist: _____ (_____) _____

Last Dental Exam: ____ /____ /____

Times a day child brushes? _____ Times a week child flosses? _____

How would you rate patients smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

Is the patient unhappy with appearance of his/her smile? ❑ Yes ❑ No

6 Patient's Medical History

Describe any current medical treatment the patient is undergoing:

_____

_____

Physician: _____ (_____) _____

Does Child have or ever had any of the following diseases, medical conditions or procedures?
Check all that apply:

❑ Heart Murmur
❑ Rheumatic Fever
❑ Artificial Heart Valves
❑ Congenital Heart defect
❑ Scarlet Fever
❑ Surgeries/Operations
❑ Cancer/Tumors/Chemotherapy
❑ Pregnancy
❑ Jaw Problems TMJ/TMD
❑ Hearing Problems
❑ Autism
❑ Tonsillitis
❑ Respiratory Problems
❑ Asthma/Difficulty Breathing
❑ Blood Transfusion(s)
❑ Leukemia/Anemia
❑ Diabetes/Hypoglycemia
❑ Hemophilia
❑ Abnormal Bleeding
❑ Cleft Lip/Palate
❑ Birth Defects
❑ High/Low Blood Pressure
❑ Hepatitis
❑ Artificial Bones/Joints/Implants
❑ Liver/Kidney/Organ Problems
❑ HIV+/AIDS/ARC
❑ Tuberculosis TB
❑ Psychiatric Problems
❑ Hyper Active/ADD
❑ Fainting/Seizures/Epilepsy
❑ Cerebral Palsy
❑ Other_____

Please list any medications currently taking: _____

_____

Is patient allergic to: ❑ Latex ❑ Nickel ❑ Motrin/Ibuprofen ❑ Food Allergies ❑ Other

Existing or Past Habits: ❑ Thumb/Finger Sucking ❑ Tongue Thrusting
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Biting ❑ Smoking/Chewing Tobacco

For Adolescent Female Patients Only: Has the patient has 1st menstrual cycle? ❑ Yes ❑ No
If yes, what age of 1st period? _____

- We invite you to discuss with us any questions regarding our services. The best Orthodontic dental services are based on a friendly, mutual understanding between provider and patient.
- Consent to Dental Photography: I agree & consent to allow photographs taken before, during and after completion of my orthodontic treatment to be used for dental records, public relations, patient counseling or other purposes.
- Consent to Dental Radiographs: Please note our xray equipment exposes our patients to minimal radiation. For example, one panoramic xray equals 2 hours of TV watching. Your safety is our top priority.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ____ /____ /____
❑ Parent or Guardian ❑ Other

UPDATE
(OFFICE USE)

_____ ___/___/___
Initials Date
_____
Comments

_____ ___/___/___
Initials Date
_____
Comments

_____ ___/___/___
Initials Date
_____
Comments