

WELCOME

to the office of
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Specialist in Orthodontics
777 Cuesta Drive, Suite 100
Mountain View, California 94040
(650) 969-0672

ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____

Nickname: _____
Last First MI

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

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home# _____

Child's Home Address: _____
Apt / Condo #

City State Zip

WITH CHILD TODAY

Name: _____ Relation: _____

Do you have legal custody of this child? No Yes

Whom may we THANK for referring you? _____

List brothers/sisters with age: _____

General Dentist: _____

Last Visit Date: _____

Parent's marital status:

Single Married Divorced Widowed Separated

PARENTS

Mother's Information: Step Mother Guardian

Name: _____

Work#: _____ ext _____ Home#: _____

Employer: _____

SS#: _____ DL#: _____

Father's Information: Step Father Guardian

Name: _____

Work#: _____ ext _____ Home#: _____

Employer: _____

SS#: _____ DL#: _____

RESPONSIBLE PARTY

Name: _____ Relation: _____

Billing Address: _____

City State Zip
Work#: _____ ext _____ Home#: _____

Employer: _____

DL#: _____ SS#: _____

Who is responsible for making appointments?

Name: _____

Work#: _____ ext _____ Home#: _____

ORTHODONTIC INSURANCE

Orthodontic Coverage: No Yes **Primary**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ & SS#: _____

Insured's Employer: _____

Orthodontic Coverage: No Yes **Secondary**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ & SS#: _____

Insured's Employer: _____

DENTAL CONCERNS

What are the main concerns that you would like orthodontics to accomplish?

Has your child ever been evaluated or had orthodontic treatment before? No Yes

Have there been any injuries to the face, mouth, teeth or chin? No Yes

List any musical instruments played _____

Have adenoids or tonsils been removed? No Yes

Has child been informed of any missing or extra permanent teeth? No Yes

Has your child ever experienced pain or discomfort in his/her jaw joint (TMJ / TMD)? No Yes

How many times does your child brush his/her teeth daily? _____

Does your child floss his/her teeth daily? No Yes

Child's Physician: _____

Phone# _____ Date of Last Visit: _____

Is your child currently under the care of a physician? No Yes

Has puberty begun? No Yes

Has menstruation begun? (girls) No Yes

Please describe your child's current physical health:

Good Fair Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

- | | |
|-------------------------|---------------------------------|
| 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 Hospitalized for Any Reason |
| Y N Asthma | Y N Kidney / Liver Problems |
| Y N Hepatitis | Y N Handicaps / Disabilities |
| Y N Tuberculosis (TB) | Y N Allergies to any Drugs |
| Y N Allergic to Plastic | Y N Allergic to Latex / Metals |

Please discuss any medical problems that your child has had:

Does your child have any of the following habits?

- | | |
|--------------------------------|---------------------|
| Y N Thumb / Finger Sucking | Y N Mouth Breather |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Clenching / Grinding Teeth | Y N Nail Biting |
| Y N Nursing Bottle Habits | Y N Tongue Thrust |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 that my child may need.

Signature of parent or guardian _____

Date _____

Thank You for filling out this form completely

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the

discretion of this office, use the services of one or more credit reporting services.

Signature of parent or guardian _____

Date _____

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

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments _____
