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

Has your child ever been prescribed Fosamax Yes No or any other bisphosphonate? If yes, when? _____

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

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

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

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No

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

Floss his / her teeth daily? Yes No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

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

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

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 / things that your child is allergic to: _____

Y N Latex Y N Metals/Nickel Y N Plastics

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

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD / ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Latex / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps / Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asperger Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

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Has your child ever experienced any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching / Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking / Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb / Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |

Neighbor or Relative not living with you.

Name _____ Phone (____) _____

Address _____

CITY _____ STATE _____ ZIP _____

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

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.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian _____ Date _____

Signature of parent or guardian _____ Date _____

Signature of parent or guardian _____ Date _____

The Parent or Guardian who accompanies the child is responsible for payment.

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

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments:

Initials: _____ Date: _____