6

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

_____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) 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?

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

Please discuss any medical problems that your child has had:

_____

_____

_____

8

Has your child ever experienced any of the following?

Y N	Clenching / Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking / Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Nail Biting	Y 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.

_____

Signature of parent or guardian **Date**

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**

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**

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.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____