

PATIENT INFORMATION FORM FOR CHILDREN

FULL NAME _____ School _____

Date of Birth _____ Age _____ Sex: Male _____ Female _____ Phone _____

Address _____ City _____ State _____ Zip _____

General Dentist Name: _____ Referred By: _____

Address: _____

City, State, Zip _____

PARENTS INFORMATION

Father's Full Name _____ Date of Birth _____

SS# _____ Married _____ Divorced _____ Separated _____ Widowed _____

Place of Employment _____

Business Address _____ Phone _____

City State Zip

Home Address _____ Phone _____

City State Zip

Mother's Full Name _____ Date of Birth _____

SS# _____ Married _____ Divorced _____ Separated _____ Widowed _____

Place of Employment _____

Business Address _____ Phone _____

City State Zip

Home Address _____ Phone _____

City State Zip

If you have moved within the last two years, list previous address.

DENTAL INSURANCE INFORMATION AND AUTHORIZATION:

Name and Address of Ins. Co. _____

Name of Subscriber _____ I.D. No. _____

Authorization:

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Relationship to Patient _____

HEALTH QUESTIONNAIRE

DATE _____

NAME _____

1. Does the patient have regular Dental-Medical exams? Yes No
Last Dental Appt. and Procedures? _____
Date of last x-rays? _____
2. Has there been any change in the patient's general health within the past year? _____
3. Is the patient under the care of a physician currently and if so for what condition? _____
4. Name and address of treating physician: _____

5. Has the patient been hospitalized or had any serious illness and if so for what condition, illness or operation? _____
6. Does the patient have or had any of the following?
 - A. Rheumatic Fever or Rheumatic Heart Disease? Yes No
 - B. Scarlet Fever? Yes No
 - C. Congenital Heart Lesions? Yes No
 - D. Mitral Valve Prolapse? Yes No
 - E. Allergies to Drugs, Anesthetics, or Other? Please Specify

 - F. Sinus problems, Hay Fever? Yes No
 - G. Asthma? Yes No
 - H. Epilepsy, Cerebral or Spastic Condition? Yes No
 - I. Blood Disorder (Anemia, Hemophilia)? Yes No
 - J. Herpes? Yes No
 - K. Hepatitis? Yes No
 - L. Tuberculosis? Yes No
 - M. HIV/AIDS? Yes No
7. Has the patient come in contact with someone with Hepatitis, Tuberculosis, or HIV/AIDS? If yes, please specify. _____
8. Has the patient ever had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
 - A. Has the patient ever required a blood transfusion?
If so, explain circumstances _____
9. Has the patient had surgery or x-ray treatment for a tumor, growth or condition of the mouth, lips? Yes No
10. Is the patient employed in any situation which they are exposed regularly to x-rays? Yes No
11. Women: Are you pregnant? Yes No

DENTAL QUESTIONNAIRE

DATE _____

NAME _____

1. Please state your reason for this orthodontic visit. _____

2. Has the patient ever experienced any of the following:

- | | | |
|--|-----|----|
| A. Trouble associated with previous dental treatment | Yes | No |
| B. Dental discomfort at this time | Yes | No |
| C. Current gum bleeding | Yes | No |
| D. Tooth sensitivity to cold, hot, sweets or chewing | Yes | No |
| E. Jaw clicking | Yes | No |
| F. Pain in or around the ears | Yes | No |
| G. Frequent sores in and around the mouth | Yes | No |
| H. Fear of dentistry | Yes | No |
| I. Had periodontal (gum) treatment | Yes | No |
| J. Had orthodontic treatment before | Yes | No |
| K. Biting habits | Yes | No |
| L. Thumb or finger sucking habits | Yes | No |

3. Does the patient breathe through their mouth primarily? Yes No

4. Does the patient grind or clench their teeth? Yes No

5. Has the patient ever been told that they have a tongue thrust or reverse swallowing pattern? Yes No

6. Have the patient's tonsils and or adenoids been removed. Yes No
If yes, please indicate which. _____

7. Is there any hereditary background, which may contribute to this orthodontic problem? Please specify. _____

Please notify the office of any change in health or dental status!!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please print patient's name)

Signature

Date

****Please note that the office "Notice of Privacy Practices" is also posted in the office lobby**