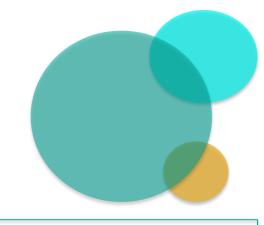


TELL US ABOUT YOUR CHILD Today's Date:_____ Nickname:_____ Child's Name: Last First MΙ E-Mail Address:_____ SS#_______ Birthdate ____/____ Age: Male Female Hobbies/Sports:____ School: Child's Home #: (_____)____ Child's Home Address: State City Zip WHO IS ACCOMPAYING YOUR CHILD TODAY? Name: Relationship:_____ Do you Have legal custody of this child? Whom may we thank for referring you? List brothers/sisters with age: _____ General Dentist: Last Visit Date: ____ Parental Martial Status: MOTHER'S INFORMATION: Step Mom Guardian Name: ______ Birthdate: ____/____ Wk#: () Ext: Hm#: () Employer:____ How Long at current Job: _____ Job Title: _____ SS#: DL#:_____ FATHER'S INFORMATION: Step Mom Guardian Name: _______ Birthdate: _____/_____/_____ Wk#: (______Ext:_____ Hm#: (____)____ Employer: How Long at current Job: Job Title: SS#: DL#:



PERSON RESPONSIBLE FOR ACCOUNT

Name:Relation:			
Billing Address:			
City	State	Zip	
Previous Address:			
City	State	Zip	
Hm#: ()	Cell#()		
DL#:SS#:_			
Employer:			
Wk#: ()	Ext:		
PRIMARY ORTHODONTIC INSURANCE			
Orthodontic Coverage:	Yes	No	
Insurance Co. Name:			
Insurance Co. Address:			
City	State	Zip	
Insurance Co. Phone #: ()		
Policy Owner's Name:			
Relationship to Patient:			
Policy Owner's Birthdate	e:/		
SS#:			
Policy Owner's Employer	r:		
Employer's Address:			
City	State	Zip	
Group # (Plan, Local or Policy #):			
Has any of your orthodontic maximum been used for			
Orthodontic treatment?	Yes	No	

What are the concerns that you would like orthodontics	HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS?
Has your child ever taken Phen-Fen? (also known as Redux or Pondimin) Has your child ever been evaluated or had orthodontic treatment before? Have there been any injuries to the face, mouth, teeth or chin? List any musical instrument played: Have adenoids or tonsils been removed? Yes No	Y N Abnormal Bleeding Y N Convulsions/Epilepsy Y N ADD/ADHD Y N Diabetes Y N Allergies to drugs Y N Handicaps/Disabilities Y N Allergies to latex Y N Allergies to metal Y N Hearing Impairment Y N Allergie to Plastic Y N Heart Murmur Y N Any Hospital Stays Y N Hemophilia Y N Any Operations Y N Hepatitis Y N HIV/AIDS Y N Asthma Y N Kidney/Liver Problems Y N Cancer Y N Tuberculosis (TB) Y N Congenital Heart Defect Y N Artificial Bones/Joints/Valves Y N Rheumatic/Scarlet Fever
Has your child been informed of any missing or extra permanent teeth? Yes No	Please discuss any medical problems your child has had:
Has your child ever had any pain or Tenderness in his/her jaw joint (TMJ/JMD)?	
Does your Child brush his/her teeth daily? Yes No	
Floss his/her teeth daily?	
Physician's Name: Phone#: (HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? Y N Nursing Bottle Habits Y N Lip Sucking/Biting Y N Speech Problems Y N Mouth Breather Y N Nail Biting Y N Tongue Thrust Y N Thumb/Finger Sucking Y N Clenching/Grinding Teeth
Please describe your child's current physical health: Good Fair Poor Please list all drugs you are currently taking: Please list all drugs/things you are allergic to:	NEIGHBOR OR RELATIVE NOT LIVING WITH YOU NAME: Phone: () Address:
	City State Zip
 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. This office reserves the right to verify the credit status of potential patients and/or parents of patients 	 I authorize the dental staff to perform any necessary dental services my child may need. If this office accepts insurance, I understand that I am Responsible for payments of services rendered and also Responsible for paying any co-payment and deductibles that my insurance does not cover.
prior to extending credit for treatment fee and may, at the discretion of one or more credit reporting services.	Signature Date
	will not hold my orthodontist or any member of his/her staff

of any changes in my child's medical or dental health.

The Parent or Guardian who accompanies this child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.