MEDINA ORTHODONTICS

TELL US ABOUT YOUR CHILD

Today's Date:_____ Nickname:_____

Child's Name:_____

Last First MI

E-Mail Address:_____

SS#_____ Birthdate ____/____/____

Age:_____ ☐ Male ☐ Female

Hobbies/Sports:_____

School:_____

Child's Home #: (_____)_____

Child's Home Address: _____

_____

City State 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: _____/_____/_____

SS#:_____

Policy Owner's Employer:_____

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 to accomplish? _____

_____

Has your child ever taken Phen-Fen? (also known as Redux or Pondimin) ☐ Yes ☐ No

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 instrument 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 or Tenderness in his/her jaw joint (TMJ/JMD)? ☐ Yes ☐ No

Does your Child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Physician's Name:_____

Phone#: (____)_____ Date of last visit _____

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

Has puberty begun? ☐ Yes ☐ No

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:

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS?

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

Please discuss any medical problems your child has had:

_____

_____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

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

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 prior to extending credit for treatment fee and may, at the discretion of one or more credit reporting services.**

- **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.

_____

Signature **Date**

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist 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.