



WELCOME TO THE ORTHODONTIST

CONFIDENTIAL

1. TELL US ABOUT YOUR CHILD

Today's Date: \_\_\_\_\_ Male  Female 
Child's Name: \_\_\_\_\_
Last First MI
Nickname: \_\_\_\_\_ SSN # \_\_\_\_ / \_\_\_\_ / \_\_\_\_
Child's Birth date: \_\_\_\_\_
School \_\_\_\_\_ Grade: \_\_\_\_\_
Hobbies / Sports: \_\_\_\_\_
Child's Home # : (\_\_\_\_) \_\_\_\_\_
Child's Home Address: \_\_\_\_\_
City State Zip

2. WHO IS ACCOMPANYING YOUR CHILD TODAY ?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_
Do you have legal Custody of this Child? Yes  No 
Whom may we thank for referring you? \_\_\_\_\_
List Brothers/Sister with ages: \_\_\_\_\_
General Dentist: \_\_\_\_\_
Last Visit Date: \_\_\_\_\_
Parent's Martial Status: Single  Married 
Separated  Widowed  Divorced

3. Mother's Information: Mother Step Mother Guardian
Name: \_\_\_\_\_ Birthday: \_\_\_\_\_
Work#: \_\_\_\_\_
Home#: \_\_\_\_\_
Employer: \_\_\_\_\_
How long at the current Job: \_\_\_\_\_
Job Title: \_\_\_\_\_
SS#: \_\_\_\_\_
DL#: \_\_\_\_\_

Father's Information : Father Step Father Guardian
Name: \_\_\_\_\_ Birthday: \_\_\_\_\_
Work#: \_\_\_\_\_
Home#: \_\_\_\_\_
Employer: \_\_\_\_\_
How long at the current Job: \_\_\_\_\_
Job Title: \_\_\_\_\_
SS#: \_\_\_\_\_
DL#: \_\_\_\_\_

4. PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_
Billing Address: \_\_\_\_\_
City State Zip
Previous Address: : \_\_\_\_\_
City State Zip
Home#: \_\_\_\_\_
DL#: \_\_\_\_\_
Employer: \_\_\_\_\_
Work#: \_\_\_\_\_
SSN#: \_\_\_\_\_
Who is responsible making appointments?
Name: \_\_\_\_\_
Work#: \_\_\_\_\_
Home#: \_\_\_\_\_

5. PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes  No 
Insurance Co. Name: \_\_\_\_\_
Insurance Co. Address: \_\_\_\_\_
Insurance Co. Phone #: \_\_\_\_\_
Group#: \_\_\_\_\_
SSN#: \_\_\_\_\_
Policy Owner's Name: \_\_\_\_\_
Relationship to Patient: \_\_\_\_\_
Policy Owner's Birthday: \_\_\_\_\_
Policy Owner's Employer: \_\_\_\_\_

SECONDARY ORTHODONTIC INSURANCE
Orthodontic Coverage? Yes  No 
Insurance Co. Name: \_\_\_\_\_
Insurance Co. Address: \_\_\_\_\_
Insurance Co. Phone #: \_\_\_\_\_
Group#: \_\_\_\_\_
SSN#: \_\_\_\_\_
Policy Owner's Name: \_\_\_\_\_
Relationship to Patient: \_\_\_\_\_
Policy Owner's Birthday: \_\_\_\_\_
Policy Owner's Employer: \_\_\_\_\_

6. What are the main concern that you would like orthodontics to accomplish? \_\_\_\_\_

Has your child ever been evaluated or had orthodontic treatment before? Y N  
have there been any injuries to the face, mouth teeth or chin? Y N  
List any musical instrument played: \_\_\_\_\_  
Have adenoid or tonsils been removed? Y N  
Has your child been informed of missing or extra permanent teeth? Y N Have you child ever had any pain / tenderness in his / here jaw join (TMJ / TMD)? Y N  
Does your child brush his / teeth daily ? Y N  
Floss his/ her teeth daily? Y N  
Child's Physician: \_\_\_\_\_  
Phone#: Date of Last Visit: \_\_\_\_\_  
Is your child currently under care of physician? Y N Has  
Puberty begun: Y N  
Has Menstruation begun?(Girl) Y N  
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 that your child is allergic to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Y N Abnormal Bleeding Y N Diabetes  
Y N Allergies to any Drugs Y N Handicaps / Disabilities  
Y N Allergic to Latex / Metal 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 Asthma Y N HIV +/- AIDS  
Y N Cancer Y N Kidney / Liver Problem  
Y N Congenial Heart Defect Y N Rheumatic / Scarlet Fever  
Y N Convulsion Y N Tuberculosis (TB)  
Please discuss any medical problem that your child has had:  
\_\_\_\_\_  
\_\_\_\_\_

8. Does / did your child have any following habits?

Y N Clenching / Grinding Teeth  
Y N Nursing Bottle Habits  
Y N Lip Sucking / Biting  
Y N Speech Problem  
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

9. 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 service my child may need.  
Signature of parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

I authorize my insurance company to pay Dr. Emeline Abay all insurance benefit otherwise payable to me for service rendered. I authorized to use of this signature on all insurance form. I authorized Dr. Emeline Abay to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.  
Signature of parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

The parent or guardian who accompanies the 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.

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_