FAMILY ORTHODONTICS of Dublin

Patient Information *Child*

First Name:_____ Last Name:_____ Nickname:_____ Sex: ☐ M ☐ F

Birthdate:_____ Age:_____ School:_____ Grade:_____

Address:_____City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

What is your preferred choice for appointment confirmations? ☐ Home Phone ☐ Cell Phone ☐ Email

Hobbies/Interests:_____

Name and Ages of Siblings:_____

Please list any family member that has been a patient in our office:_____

Patient lives with:_____ Relationship to the patient:_____

Whom may we thank for referring you to our office?_____

Dentist Name:_____ Phone:_____ City:_____

Person Responsible for this Account

Name:_____ Relationship to the patient:_____

Address:_____City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Remarried

Mother's Name:_____ Social Security #_____-_____-_____ Driver's Lic #_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____

Father's Name:_____ Social Security #_____-_____-_____ Driver's Lic #_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____

Dental Insurance

Mother's Dental Insurance:_____ Group #_____

Subscriber's ID:_____ Mother's Birthdate:_____

Insurance Phone: _____

Father's Dental Insurance:_____ Group #_____

Subscriber's ID:_____ Father's Birthdate:_____

Insurance Phone: _____

(Continued on back)

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Medical and Dental History

Does your child currently have or have they ever had any of the following (*please check yes or no*):

Arthritis	Yes	No	Epilepsy	Yes	No	Metal Allergy	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Mouth Breathing	Yes	No
Back or Neck problems	Yes	No	Head/brain injury	Yes	No	Nervous disorders	Yes	No
Bleeding disorder	Yes	No	Heart murmur	Yes	No	Periodontal (Gum) Problems	Yes	No
Bone disorder	Yes	No	Heart problems	Yes	No	Rheumatic Fever	Yes	No
Bulimia	Yes	No	Hepatitis	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Tooth Grinding	Yes	No
Chest Pains	Yes	No	Jaw or Jaw joint Pain	Yes	No	Trauma to face/teeth	Yes	No
Diabetes	Yes	No	Latex Allergy	Yes	No	Tuberculosis (TB)	Yes	No

Does your child have any disease, problem, or illness not mentioned above? ☐ No ☐ Yes, please specify: _____

_____

Does your child currently take any medications? ☐ No ☐ Yes, please list: _____

_____

Does your child have any allergies? ☐ No ☐ Yes, please specify: _____

_____

Physician: _____ Phone:_____ City:_____

Last date seen by physician: _____

Female Patients: Has your child begun menstruation? ☐ No ☐ Yes If so, at what age did menstruation begin? _____

Has your child ever sucked a thumb or finger? If so, to what age? _____	Yes	No
Any speech problems?	Yes	No
Any breathing problems?	Yes	No
Any pain or noises while opening or closing the mouth?	Yes	No
Are you aware of any missing or extra teeth?	Yes	No
Are you aware of any tongue-thrust problems?	Yes	No
Have you consulted with another orthodontist about your child's problem?	Yes	No
Has your child had previous orthodontic treatment?	Yes	No
For the patient: Are you happy with the way your teeth look now?	Yes	No
For the patient: Are you willing to wear metal braces, elastics, retainers, etc. to help straighten your teeth?	Yes	No

What are your reasons for choosing to seek orthodontic treatment? _____

_____

I, _____ authorize this facility to examine and provide orthodontic treatment. I accept full responsibility for any balance due. I authorize my insurance company to make payments directly to this facility when applicable. I understand it is my responsibility to know all the rules and restrictions of my insurance policy including orthodontics. I authorize this facility to release any dental or incidental information that may be necessary for either dental care or in processing application for financial benefit. I understand that this office reserves the right to verify the credit status of potential patients or responsible party/guardian 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.

Patient or Responsible Party:

Signature_____**Date**_____

(Rev.010411)