Bastrop
708 Pecan
Bastrop, TX 78602
(512) 303-1060

www.bracesbastrop.com

Steiner Ranch Orthodontics
4302 N Quinlan Park Rd.
Austin, TX 78732
(512) 266-8585

Central Austin
1814 W. 35th Street
Austin, TX 78703
(512) 451-6457

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JAMES WATERS ORTHODONTIST

1 Tell Us About Your Child

Today's Date: 01-10-2012 ☐ Male ☑ Female

Child's Name: paltola (LAST) ahsiwni (FIRST) (MI)

Nickname: ashu SS#:

Child's Birthdate: 04-05-1995 Child's Age: 16

School: Grade:

Hobbies / Sports:

Child's Home #: (512) 275-6302

Child's Home Address: , hjui

(CITY) CO (STATE) 78728-1111 (APT/CONDO # / ZIP)

E-Mail Address: hyhuioujhy

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 / sisters with age:

General Dentist:

Last Visit Date: 06-06-2007

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

3 Mother's Information: ☐ Step Mother ☐ Guardian

Name: Birthdate: 07-05-1953

Wk #: ( ) Ext: Hm #: ( )

Employer:

How Long at Current Job: Job Title:

SS #: DL #:

Father's Information: ☐ Step Father ☐ Guardian

Name: Birthdate: 05-05-1957

Wk #: ( ) Ext: Hm #: ( )

Employer:

How Long at Current Job: Job Title:

SS #: DL #:

4 Person Responsible For Account

Name: Relation:

Billing Address: ,

(CITY) (STATE) (ZIP)

Previous Address: ,

(CITY) (STATE) (ZIP)

Hm #: ( ) DL #:

Employer:

Wk #: ( ) Ext: SS #:

Who is responsible for making appointments?

Name:

Wk #: ( ) Ext: Hm #: ( )

Neighbor or Relative not living with you.

Name: Phone: ( )

Address: ,

(CITY) (STATE) (ZIP)

5 Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #: ( )

Group # (Plan, Local, or Policy #):

Policy Owner's Name:

Relationship to Patient:

Policy Owner's Birthdate: 06-07-1948 SS #:

Policy Owner's Employer:

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #: ( )

Group # (Plan, Local, or Policy #):

Policy Owner's Name:

Relationship to Patient:

Policy Owner's Birthdate: 08-05-1947 SS #:

Policy Owner's Employer:

CONTINUED ON BACK

6

What are the main concerns that you would like orthodontics to accomplish?

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 instruments 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 / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____)_____ Date of Last Visit: 06-07-2005

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

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/things that your child is allergic to:

7

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

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	ADD / ADHD	Y	N	Handicaps / Disabilities
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Allergic to Latex / Metals	Y	N	Heart Murmur
Y	N	Allergic to Plastic	Y	N	Hemophilia
Y	N	Any Hospital Stays	Y	N	Hepatitis
Y	N	Any Operations	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
			Y	N	Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

8

Does/did your child have any of the following habits?

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

Was your child breast fed? Y N

9

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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 services my child may need. If this office accepts insurance, I assign directly to Dr. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

My method of payment will be: _____

_____
Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents 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.

_____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: _____ Date: _____