

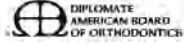


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Bastrop, TX 78602
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1

Tell Us About Your Child

Today's Date: 11-27-2012

☐ Male

☐ Female

Child's Name: ,

LAST

FIRST

MI

Nickname: _____

SS#: _____

Child's Birthdate: _____

Child's Age: _____

School: _____

Grade: _____

Hobbies / Sports: _____

Child's Home #: () _____

Child's Home Address: _____

APT/CONDO #

CITY

STATE

ZIP

E-Mail Address: _____

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

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: _____

Parent's Marital Status:

☐ Single

☐ Widowed

☐ Married

☐ Divorced

☐ Separated

3

Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____

Birthdate: _____

Wk #: () _____

Ext: _____

Hm #: () _____

Employer: _____

How Long at Current Job: _____

Job Title: _____

SS #: _____

DL #: _____

Father's Information: ☐ Step Father ☐ Guardian

Name: _____

Birthdate: _____

Wk #: () _____

Ext: _____

Hm #: () _____

Employer: _____

How Long at Current Job: _____

Job Title: _____

SS #: _____

DL #: _____

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: _____ 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: _____ SS #: _____

Policy Owner's Employer: _____

CONTINUED ON BACK

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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: _____

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	Asthma	Y N	Liver Problems
Y N	Cancer	Y N	Lupus
Y N	Congenital Heart Defect	Y N	Rheumatic / Scarlet Fever
Y N	Convulsions / Epilepsy	Y N	Sickle Cell Disease / Traits
		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

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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.

OFFICE USE ONLY 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: _____