Ortho - Child New Patient

Patient Information	
Patient Name	
Gender	Male Female
Patient SSN	
Patient DOB	
Patient Age	
Patient Home Address	
Patient City	
Patient State	
Patient Zip	
Patient Primary Phone #	
Patient primary phone type	Home Cell
Patient E-mail	
Patient School	
Patient Grade	
Patient List any sports or extracurricular activities	
Patient Siblings (names and ages)	
Parent/Guardian Information	
Parent Marital Status	Single Married Divorced Widowed Significant Other
Parent1 Relationship	
Parent1 Name	
Parent1 SSN	
Parent1 Birth Date	
Parent1 DL #	
Parent1 Address	
Parent1 City	
Parent1 State	
Parent1 Zip	
Parent1 Phone Number	
Parent1 Phone Type	Home Cell
Parent1 Secondary Phone #	
Parent1 Secondary Phone Type	Home Cell
Parent1 Employer	
Parent1 Occupation	
Parent2 Type	
Parent2 Name	
Parent2 SSN	
Parent2 Birth Date	
Parent2 DL#	
Parent2 Address	
Parent2 City	

Parent2 State	
Parent2 Zip	
Parent2 Phone	
Parent2 Phone Type	Home Cell
Parent2 Second Phone #	
Parent2 Secondary Phone Type	Home Cell
Parent2 Occupation	
Parent2 Employer	
Emergency Contact	
Emergency Name	
Emergency Phone #	
Emergency Relation to child	
Emergency Address	
Emergency City	
Emergency State	
Emergency Zip	
Person(s) OK to release appointment or medically related information to concerning child.	
Emergency Relation	
Insurance Information	
PRI. INS. Company	
PRI. INS. Phone #	
PRI. INS.Group #	
PRI. INS. Policy #	
PRI. INS. Member ID #	
PRI. INS. Policy Holder’s Name	
PRI. INS. Relation	
PRI. INS. Policy Holder's SSN	
Policy Holder’s DOB	
PRI. INS. Employer	
PRI. INS. Work Phone #	
PRI. INS. co-pay	
PRI. INS. Deductible	
SEC. INS. Company	
SEC. INS. Phone #	
SEC. INS. Group #	
SEC. INS. Policy #	
SEC. INS. Member ID #	
SEC. INS. Policy Holders Name	
SEC. INS. Relation	
SEC. INS. Policy Holder's SSN	
SEC. INS. Holder's DOB	
SEC. INS. Employer	
SEC. INS. Work Phone #	
SEC. INS. Co-pay	
SEC. INS. Deductable	
Dental History	
General Dentist	
Last Visit	

How did you hear about our Practice?	Ad Internet Family or Friend Physician Other
Dental Name of person referring	
Concerns	
Has your child visited an orthodontist before?	Yes No
When	
Reason	
Has your child's tonsils or adenoids been removed?	Yes No
Has your child ever experienced jaw joint pain/discomfort (TMJ/TMD)?	Yes No
Does your child have any missing or extra permanent teeth?	Yes No
Has your child ever had an injury to	Teeth Mouth Chin
Does your child have speech problems?	Yes No
If so, explain	
Does your child currently or has your child ever had any of the following habits	Clenching/Grinding Teeth Lip Sucking/Biting Mouth Breathing Nail biting Thumb/ Finger Sucking Chewing/Eating Problems
Medical History	
Is your child currently being treated by a physician?	Yes No
Reason	
Physician	
Deductible (if known)	
Medical Phone	
Does your child have any allergies/sensitivities to medications or latex?	Yes No
If yes, please list allergies	
Is your child currently taking any prescription or over-the-counter medications?	Yes No
Please list, with dosage	
Has your child ever taken any of the group of drugs collectively referred to as “fen-phen?” These include combinations of lonimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?	Yes No

Has your child had any serious illnesses or operations? If yes, describe	
Has your child ever had a blood transfusion?	Yes No
If yes, give approximate dates	
Check if your child has or have ever had any of the following	Anemia Arthritis, Rheumatism Artificial Heart Valves Artificial Joints Asthma Back Problems Blood Disease Cancer Chemical Dependency Chemotherapy Circulatory Problems Cortisone Treatments Cough, Persistent Coughing Blood Diabetes Epilepsy Fainting Glaucoma Headaches Heart Murmur Heart Problems Hemophilia Hepatitis High Blood Pressure HIV/AIDS Jaw Pain Kidney Disease Liver Disease Mitral Valve Prolapse Pacemaker Radiation Treatment Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Skin Rash Stroke Swelling of Feet or Ankles Thyroid Problems Tobacco Habit Tonsillitis Tuberculosis Ulcer Venereal Disease
Authorization	

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature

Date