WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you.

Patient Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SEX)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Nickname _____ Birthdate _____ (MM-DD-YYYY) Email _____ SSN _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999)

General Dentist _____ Last Visited _____

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

Father's Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SEX) _____ (MARITAL STATUS)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) Ext _____

Birthdate _____ (MM-DD-YYYY) Email _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Mother's Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SEX) _____ (MARITAL STATUS)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) Ext _____

Birthdate _____ (MM-DD-YYYY) Email _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

General Information

School _____

Brothers & Sisters (Include ages.)

Hobbies

Medical History

Ricci ORTHO

Is the child under the care of a physician? ☐ Yes ☐ No If Yes, explain _____

Physician _____ Phone _____ Last visit _____

Address _____

Has puberty begun? ☐ Yes ☐ No Has menstruation (period) begun? ☐ Yes ☐ No ☐ NA

What are the main concerns you would like orthodontics to correct? _____

Has the patient ever been evaluated for orthodontic treatment? _____

Does the patient have any missing or extra permanent teeth? ☐ Yes ☐ No Have the patient's tonsils or adenoids been removed? ☐ Yes ☐ No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Has the patient ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Does the patient have speech problems? ☐ Yes ☐ No If Yes, explain _____

Has the patient ever received gum treatment? ☐ Yes ☐ No If Yes, explain _____

Does the patient have or ever had any of the following habits?

☐ Lip sucking ☐ Nail biting ☐ Prolonged bottle / pacifier
☐ Clenching / grinding teeth ☐ Mouth breather ☐ Tongue thrusting ☐ Thumb / finger sucking

Please check Yes or No to the following and give date:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
ADD / ADHD	☐	☐		Epilepsy	☐	☐		Lung Disorder	☐	☐	
Anemia	☐	☐		Eye Disorder	☐	☐		Mitral Valve Prolapse	☐	☐	
Arthritis	☐	☐		Glaucoma	☐	☐		Neurological Disorder	☐	☐	
Asthma	☐	☐		Hearing Disorder	☐	☐		Psychiatric Disorders	☐	☐	
Blood Disorder	☐	☐		Heart Attack	☐	☐		Radiation Treatment	☐	☐	
Bone Disorder	☐	☐		Heart Disorder / Defect	☐	☐		Rheumatic / Scarlet Fever	☐	☐	
Breathing Difficulties	☐	☐		Heart Murmur	☐	☐		Seasonal Type Allergies	☐	☐	
Cancer	☐	☐		Hepatitis	☐	☐		Seizures	☐	☐	
Convulsions	☐	☐		High Blood Pressure	☐	☐		Sickle Cell Anemia / Trait	☐	☐	
Diabetes	☐	☐		HIV+ / AIDS	☐	☐		Stroke	☐	☐	
Dizziness	☐	☐		Immune System Disorder	☐	☐		Surgery / Hospitalization	☐	☐	
Drug / Alcohol Abuse	☐	☐		Joint Replacement	☐	☐		Thyroid Disorder	☐	☐	
Eating Disorder	☐	☐		Kidney Disorder	☐	☐		Tuberculosis	☐	☐	
Endocrine Disorder	☐	☐		Liver Disorder	☐	☐		Ulcers	☐	☐	

Other _____

Please give greater details where necessary _____

Is the child allergic to any of the following?

☐ Aspirin ☐ Erythromycin
☐ Codeine ☐ Penicillin
☐ Tetracycline ☐ Latex
☐ Any Metals / Plastics

Other Allergies / Sensitivities:

List all drugs the patient is currently taking

List any serious medical condition(s) treated

Insurance Information

Policy Owner's Name _____ Policy Owner's SSN _____
999-99-9999

Birthdate _____ Relationship to Patient _____
MM-DD-YYYY

Policy Owner's Employer _____ Address _____

Insurance Company _____ Group No. (plan, local or policy) _____

Insurance Co. Address _____ Phone _____
999-999-9999

Secondary Insurance:

Policy Owner's Name _____ Policy Owner's SSN _____
999-99-9999

Birthdate _____ Relationship to Patient _____
MM-DD-YYYY

Policy Owner's Employer _____ Address _____

Insurance Company _____ Group No. (plan, local or policy) _____

Insurance Co. Address _____ Phone _____
999-999-9999

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____

Date _____