smith orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
Last First M. Ini.

Child's Birthdate: _____ Age _____

Nickname:_____ ❑ Male ❑ Female

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home#: ( )_____ SS#_____

Child's Home Address:_____

_____
City State Zip

2 Who Is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ❑ Y ❑ N

Whom may we Thank for referring you? _____

List brothers/sisters with age:_____

_____

General Dentist:_____

Last Exam Date:_____Any cavities?_____

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

3 Parent's Information

Mother ❑ Step Mother ❑ Guardian

Name:_____ DOB:_____

Hm#:( ) _____ Cell#:( )_____

Employer:_____

How long at current job?_____ Wk#:( ):_____

SS#:_____ DL#:_____

Father ❑ Step Father ❑ Guardian

Name:_____ DOB:_____

Hm#:( ) _____ Cell#:( )_____

Employer:_____

How long at current job?_____ Wk#:( ):_____

SS#:_____ DL#:_____

4 Financially Responsible For Account

Name:_____ Relation:_____

Billing Address:_____

_____
City State Zip

Email Address:_____

DL#:_____ SS#:_____

Employer:_____

Wk#: ( )_____ Hm#: ( )_____

5 Primary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No

Primary Insurance Co. Name:_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's DOB:_____

Policy Owner's SS#:_____

6 Secondary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No

Secondary Insurance Co. Name:_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's DOB:_____

Policy Owner's SS#:_____

7 What would you like orthodontics to accomplish?

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child even had any pain / tenderness in his / her jaw joint (TMI/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#: ( )_____

Date of Last Visit:_____

Is child currently under the care of a physician? Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

Please list all drugs/things that the child is allergic to:

_____

_____

_____

8 Has your child had any of the following Dental/medical problems:

Dental:

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

Medical:

Y N Abnormal Bleeding
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

_____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential 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 agencies. In the event that the account is turned over to collections, account holder is responsible for any fees incurred.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent / guardian & patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____