

Dental Insurance Information

Insured's Name: _____ Insured's SS# or ID#: _____ - _____ - _____
 Insurance Company: _____ Group No. _____ Local No: _____
 Insurance Co. Address _____ Phone #: (____) _____ - _____

City State Zip

Do you have dual coverage? Yes No If Yes:

Insured's Name: _____ Insured's SS# or ID#: _____ - _____ - _____
 Insurance Company: _____ Group No. _____ Local No: _____
 Insurance Co. Address _____ Phone #: (____) _____ - _____

City State Zip

Dental & Medical History

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

Has your 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

Does the child require antibiotics before dental treatment? Y N
 Have adenoids or tonsils been removed? Y N
 Does your child have any missing or extra permanent teeth? Y N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/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 the child currently under the care of a physician? Y N
 Has puberty begun? Y N
 Has menstruation started? Y N

Please describe the child's current physical health? Good Fair Poor
 Please list all drugs that the child is currently taking?

Aside from items listed below, list all drugs/things your child is allergic to:

Latex: Y N Nickel/ Metals: Y N Plastic: Y N

Has the child experienced the following medical problems?
 Y N Abnormal Bleeding Y N Hemophilia
 Y N ADD/ADHD Y N Hepatitis
 Y N AIDS/ HIV+ Y N Kidney Problems
 Y N Any Hospital Stays/Operations _____
 Y N Artificial Bones/Joint/Valves _____
 Y N Asthma Y N Liver Problems
 Y N Cancer Y N Mitral Valve Prolapse
 Y N Congenital Heart Defect
 Y N Convulsions Y N Prosthetics
 Y N Diabetes Y N Rheumatic Fever
 Y N Epilepsy Y N Scarlet Fever
 Y N Hearing Impairments Y N Tuberculosis (TB)
 Y N Handicaps/Disabilities
 Y N Heart Murmur Y N Sickle Cell Disease/Traits

Is the child currently taking medication for osteoporosis? Y N
 If so, the name? _____

Are the child's immunizations current? Y N
 Anything you would like to discuss with the Doctor in private? Y N

Please describe any serious medical problem the child has had:

Does/did the child experience any of the following?
 Y N Breast Fed Y N Nursing Bottle Habits
 Y N Clenching/Grinding Teeth
 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
 Y N Used Pacifier

List any musical instruments played: _____

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that 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/orthodontic services my child may need.

 Signature of Parent or Guardian

 Date