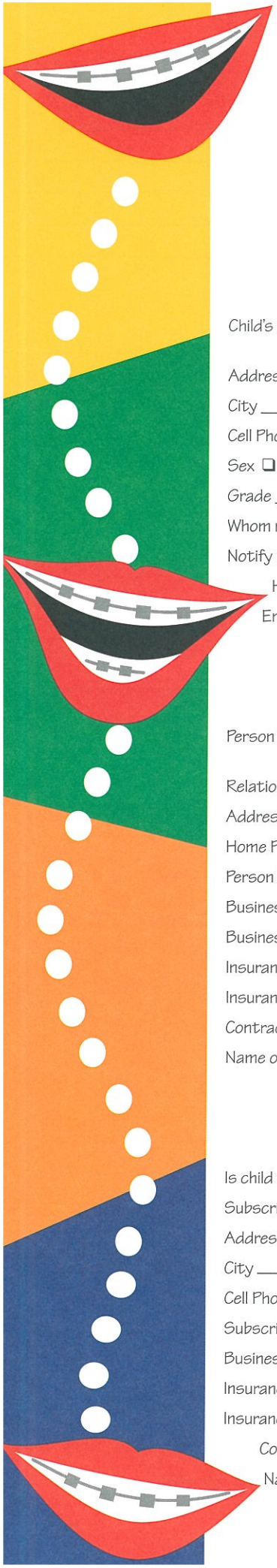


Welcome!

We are pleased to welcome you and your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name _____ (Last Name) _____ (First Name) _____ (Initial) Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Relation to child _____

Home Phone _____ Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____ (Last Name) _____ (First Name) _____ (Initial)

Relation to Child _____ Birthdate _____ Soc. Sec. # _____

Address (if different from child) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Insurance Company Phone _____

Insurance Company Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is child covered by additional orthodontic insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Child _____ Birthdate _____

Address (if different from child) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

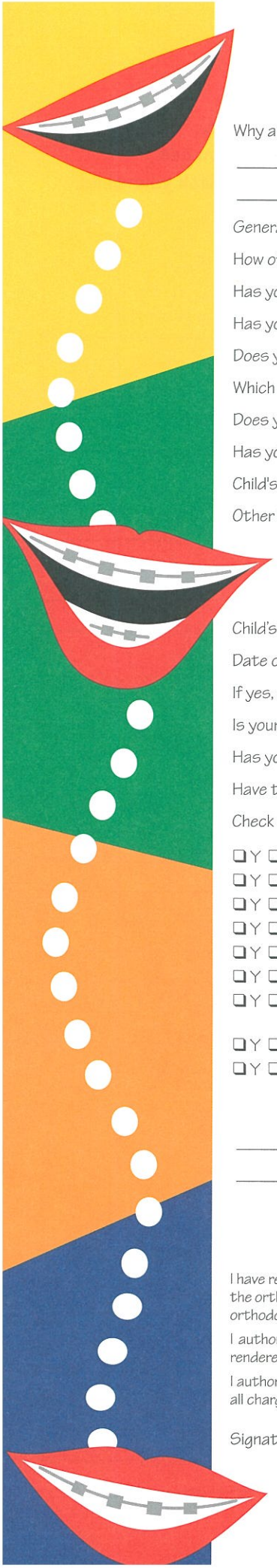
Insurance Company _____ Insurance Company Phone _____

Insurance Company Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.



Dental History

Why are you interested in orthodontic treatment for your child? _____

_____

_____

General Dentist _____ Date of last dental care _____

How often does your child brush? _____ Floss? _____

Has your child ever been evaluated for othodontic treatment? ❑Y ❑N

Has your child ever experienced a mouth or chin injury? ❑Y ❑N

Does your child have any habits/problems affecting the mouth or teeth? _____

Which musical instruments does your child play? _____

Does your child usually breathe through his/her mouth while awake? ❑Y ❑N Or asleep? ❑Y ❑N

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Child's habits affecting the mouth or teeth: ❑Thumb sucking ❑Nail biting ❑Other _____

Other information about your child's dental health or previous treatment _____

Medical History

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? ❑Y ❑N

If yes, describe _____

Is your child currently under physician care? ❑Y ❑N If yes, describe _____

Has your child ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____

Have the child's adenoids or tonsils been removed? ❑Y ❑N

Check (✓) yes or no if your child has had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anemia
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Convulsions/ Epilepsy
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood

❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Headaches
❑Y ❑N Heart problems
Describe _____
_____
❑Y ❑N Hearing Impairment

❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/ Scarlet fever

❑Y ❑N Shortness of breath
❑Y ❑N Sinus problems
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Other _____
_____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.