Information Form for Patients under 18

Today's Date _____/_____/_____ CONFIDENTIAL

PATIENT

First name _____Last name_____ Middle initial _____

Patient prefers to be called _____ Birthdate _____/_____/_____ Sex: ☐ Male ☐ Female

School _____ Grade_____

Home address: Street_____

City _____ State _____ Zip code _____

Home phone _____ E-mail address_____

PARENT/GUARDIAN #1 – This person lives with the patient at the address given in the above section

Full name_____ Relationship to patient_____

E-mail address_____ Social Security # _____ - _____ - _____

Employer_____ Occupation_____

Home phone _____ Cell phone _____ Work phone _____

PARENT/GUARDIAN #2 – This person may be a second parent, the closest relative, or an emergency contact

Full name_____ Relationship to patient_____

E-mail address_____ _____ Social Security # _____ - _____ - _____

Employer_____ Occupation_____

Home phone _____ Cell phone _____ Work phone _____

DENTIST

Name of patient's Dentist _____City _____ State _____

Date last seen _____/_____/_____ Reason _____

GENERAL INFORMATION

Who/what had the <u>most</u> influence in you contacting our practice? ☐ Friend/family member ☐ Dentist ☐ Hygienist/dental staff

☐ Website/Internet search ☐ Facebook page ☐ Magazine ad ☐ Local banner ☐ Insurance provider ☐ Local event ☐ Other

Has the patient had any previous orthodontic treatment? _____

Have any other family members been treated in this office? _____ Please name them:_____

MEDICAL HISTORY

For the following questions, use a separate sheet of paper if necessary.

Please list any and all medical conditions with which the patient has been diagnosed.

_____

Please list any and all medical conditions or events for which the patient has been hospitalized.

_____

Please list any and all surgical procedures that the patient has had or is planning to have in the future.

_____

Please list all medications the patient is currently taking, and why he/she is taking them.

_____

If there are any medications the patient has taken in the past, but is not currently taking, please list them below.

_____

Please list any and all allergies. Don't forget allergies to medications, latex, nickel, and local anesthetics.

_____

Do you feel patient has "TMJ" (jaw joint) problems?_____ Has patient ever been treated for "TMJ"?_____

Has the patient ever had an orthodontic consultation before now? _____

Females: Is the patient pregnant? _____

PHYSICIAN

Name of patient's physician _____City_____ State_____

Office phone number _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different than patient address) Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

E-mail address _____

Social Security # _____ - _____ - _____ Employer_____

DENTAL INSURANCE

Policy holder's full name _____ Birthdate_____/_____/_____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address of Insured (if not listed above) Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

Employer _____ Insurance company_____

Insurance phone # _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Signature_____ Date_____/_____/_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Signature_____ Date_____/_____/_____