PATIENTS UNDER 18 YEARS OF AGE INFORMATION FORM

Today's Date ____/____/____

ABOUT THE PATIENT

Name _____ Nickname _____
LAST FIRST MIDDLE

Patient's Birthday _____/_____/_____ Patient's Age _____ Male _____ Female _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____

Patient's Home # (_____)_____ SS # _____

School _____ Grade _____ Sports/Hobbies _____

Whom may we thank for referring you? _____

PARENT/GUARDIAN INFORMATION

Who is responsible for the account?_____

Parent's Marital Status: Single___ Married___ Partnered___ Widowed___ Divorced___ Separated___

Father_____ Step Father_____ Guardian_____

Name _____ Birthday _____/_____/_____

Address(if differs from patient) _____

_____

SS # _____ Email _____

Work # (____)_____ Home # (_____)_____ Cell # (_____)_____

How would you like to be reminded of future appointments? Call _____ Text_____ Email_____

Employer _____ Occupation _____

Insurance Co. _____ Insurance Address_____

_____ Phone # (_____)_____

CITY STATE ZIP CODE

ID #_____ Group # _____

Mother_____ Step Mother _____ Guardian_____

Name _____ Birthday _____/_____/_____

Address(if differs from patient) _____

_____

SS # _____ Email _____

Work # (_____)_____ Home # (_____)_____ Cell # (____)_____

Employer _____ Occupation _____

Insurance Co. _____ Insurance Address_____

_____ Phone # (_____)_____

CITY STATE ZIP CODE

ID #_____ Group # _____

EMERGENCY INFORMATION

Relative or friend not living with you:

Name _____ Relation _____

Phone # (_____)_____ Address _____

I understand that payment is due IN FULL at the time of treatment unless prior arrangements have been approved. I understand that this office reserves the right, when appropriate, to obtain credit bureau reports of patients and/or parties responsible for the account. I understand that I am responsible for payment of services rendered, as well as any co-payment or deductible that insurance does not cover. I authorize the dentist to release any information necessary to obtain payment of benefits. Furthermore, I directly assign to the doctor all insurance benefits otherwise payable to me.

Signature of Parent or Guardian _____ Date ___/___/___

DENTAL AND MEDICAL HISTORY

General Dentist _____ Dentist's Phone # (_____)_____

Physician _____ Physician's Phone # (_____)_____

Main concerns patient would like orthodontic treatment to accomplish? _____

Has the patient been evaluated or had orthodontic treatment before? _____

Has the patient had any injuries to the face, mouth or teeth? Yes ____ No ____

Does the patient require antibiotics before dental treatment? Yes ____ No ____

Have the patients tonsils or adenoids been removed? Yes ____ No ____

Does the patient have any missing or extra permanent teeth? Yes ____ No ____

Has the patient ever had any pain or tenderness in their jaw joint? Yes ____ No ____

Does the patient brush their teeth daily? Yes ____ No ____ Floss daily? Yes ____ No ____

Is the patient under the care of a physician? Yes ____ No ____

Has puberty or menstruation begun? Yes ____ No ____

Describe patient's current physical health: Good ____ Fair ____ Poor ____

Please list any medications the patient is currently taking: _____

Is the patient allergic to:

Latex? Yes ____ No ____ Nickel/Metals? Yes ____ No ____ Plastic? Yes ____ No ____

Any other drugs/things patient is allergic to: _____

Mark X on any of the medical conditions the patient has had or currently has:

Abnormal bleeding/Hemophilia____
Pneumonia____
Herpes____
Epilepsy____
Asthma/Hay Fever____
Rheumatic Fever____
Kidney Problems____
Heart Murmur____
Diabetes____
Anemia____
Prolonged Bleeding____
High Blood Pressure____
Gastrointestinal Disorders____
Bone Disorders____
Tuberculosis____
Nervous Disorders____
Hepatitis/Liver problems____
Dizziness____
Arthritis____
Radiation/Chemotherapy____
HIV/AIDS____
Heart Problems____
Congenital Heart Defect____
Tumor or Cancer____

Any medical conditions not listed that the doctor should be aware of?_____

Any the patients immunizations current? Yes ____ No ____

Anything you would like to discuss with the doctor in private? Yes ____ No ____

Mark X if the patient experienced or experiences any of the following?

Breast Fed____
Speech Problems____
Mouth Breather____
Use Pacifier____
Nursing Bottle Habits____
Lip Sucking/Biting____
Tongue Thrust____
Clenching/Grinding Teeth____
Thumb/Finger Sucking____
Nail Biting____

List any musical instruments played:_____

BENEFITS

Benefits of Orthodontics: aesthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth in the general function of the teeth and in general dental health. Teeth, gums and jaws are intricate body parts of the body and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout your lifetime and there can be some movement of the teeth and some changes after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for education and promotional purposes. I have truthfully answered all the questions above to the best of my ability and

agree to inform the office of any changes in the medical or dental history. In addition, I authorize Dr. Patel to perform a complete orthodontic evaluation.

Signature_____ Date_____/_____/_____

OFFICE USE ONLY

I verbally reviewed the medical/ dental information with the patient named herein.

Signature: _____ Date: _____/_____/_____

Doctor's Comments: _____

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