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:_________________________ ❑ Female ❑ Male

School:____________________________ Grade:_______

Hobbies/Sports: __________________________________

Child's Home#:( )____________ SSN______________

Child's Home Address:____________________________

____
City State Zip

Whom may we thank for referring you? _______________

General/Pediatric Dentist:__________________________

Last Exam Date:_________________Any cavities? ❑ Y ❑ N

2 Who Is Accompanying The Child Today?

Name:______________________ Relation:____________

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

Child resides with: ❑ Mother ❑ Father ❑ Other

Is there a Court Order regarding child's residence? ❑ Y ❑ N

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

3 Parent's Information

Father ❑ Step Father ❑ Guardian

Name:_____________________ TDL#:_______________

Wk#:( ) __________________Ext.__________________

Hm#:( )_______________________________________

Cell#:( )______________________________________

Email:____

Address (if different from above)

____

Employer: _____________________________________

Mother ❑ Step Mother ❑ Guardian

Name:_____________________ TDL#:_______________

Wk#:( ) __________________Ext.__________________

Hm#:( )_______________________________________

Cell#:( )______________________________________

Email:____

Address (if different from above)

____

Employer:______________________________________

4 Person Responsible For Account

Name:______________________ Relation:_____________

Billing Address:___________________________________

____
City State Zip

Hm#:( )_______________ TDL#:___________________

Employer:_____________________________________

Wk#:( )____________________________Ext.________

Cell#:( )_______________________________________

to receive confirmations via text:___________________

SSN:____

5 Primary Dental Insurance

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

Insurance Co. Name:_____________________________

Insurance Co. Address:___________________________

Insurance Co. Phone#: ( )_________________________

Group# (Plan, Local, or Policy #):___________________

Policy Owner's Name:____________________________

Relationship to Patient:__________________________

Policy Owner's DOB:_____________________________

Policy Owner's SSN:_____________________________

Please inform us if you have secondary dental insurance

6 Does/Did The Child Have Any Of The Following?

Y N Clenching/Grinding
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail/Cheek Biting
Y N Fluoride supplements
Y N Food impaction
Y N Pain around ear
Y N Bad Breath
Y N Water Jet Device
Y N Burning Tongue
Y N Teeth senstive to cold,heat, sweets or pressure
Y N Swelling or lumps in mouth
Y N Periodontal Treatment
Y N Cigarette/Tobacco use
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Any dental problem not listed above

If Yes, please describe:

____

____

7 What would you like orthodontics to accomplish?

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____

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 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 child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) 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:

____

____

____

Please notify us if your child gets pregnant to avoid the taking of dental x-rays during treatment.

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

Y	N	Abnormal Bleeding	Y	N	Thyroid Issues
Y	N	Allergies to Any Drugs	Y	N	Malignancies
Y	N	Allergic to Latex/Metals	Y	N	Epilepsy/Seizures
Y	N	Allergic to Plastics	Y	N	Radiation Treatment
Y	N	Any Hospital Stays	Y	N	Joint Replacement
Y	N	Any Operations	Y	N	Learning Disability
Y	N	Arthritis	Y	N	Difficulty Breathing
Y	N	Artificial Valves	Y	N	Eye Disorders
Y	N	Asthma	Y	N	Ulcers/Colitis
Y	N	Hay Fever/Allergies	Y	N	Veneral Disease
Y	N	Cancer/Chemotherapy	Y	N	Drug Abuse
Y	N	Congenital Heart Defect	Y	N	Emphysema
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Diabetes	Y	N	Fever Blisters
Y	N	Handicaps/Disabilities	Y	N	Hepatitis
Y	N	Hearing Impairment	Y	N	Pacemaker
Y	N	Heart Murmur	Y	N	Headaches
Y	N	Mitral Valve Prolapse	Y	N	Migraines
Y	N	Heart Ailments	Y	N	Shingles
Y	N	Anemia/Hemophilia	Y	N	Heart Attack
Y	N	High/Low Blood Pressure	Y	N	HIV +/ AIDS
Y	N	Kidney/Liver Problems	Y	N	Psychiatric Care
Y	N	Rheumatic/Scarlet Fever			
Y	N	Tuberculosis (TB)			
Y	N	Any medical issue not listed above			

If Yes to any above, please describe:

____

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 even if I am not present in the treatment area.

____

Signature of parent or guardian Date

I authorize and direct payment of the dental benefits offered by my dental insurance for treatment performed to Fullerton Orthodontics. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with treatment performed.

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Signature of parent or guardian Date

DOCTOR USE ONLY BELOW

I verbally reviewed the medical/dental information above with the parent/guardian named herein.

Doctor Comments: Initials: ____________ Date: ____________

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