Fullerton ORTHODONTICS

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#:( )_____

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	Food impaction
Y	N	Lip Sucking/Biting	Y	N	Pain around ear
Y	N	Mouth Breather	Y	N	Bad Breath
Y	N	Nail/Cheek Biting	Y	N	Water Jet Device
Y	N	Fluoride supplements	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?

_____

_____

_____

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 Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Arthritis
Y N Artificial Valves
Y N Asthma
Y N Hay Fever/Allergies
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Glaucoma
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Heart Ailments
Y N Anemia/Hemophilia
Y N High/Low Blood Pressure
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis (TB)
Y N Any medical issue not listed above

Y N Thyroid Issues
Y N Malignancies
Y N Epilepsy/Seizures
Y N Radiation Treatment
Y N Joint Replacement
Y N Learning Disability
Y N Difficulty Breathing
Y N Eye Disorders
Y N Ulcers/Colitis
Y N Veneral Disease
Y N Drug Abuse
Y N Emphysema
Y N Sinus Problems
Y N Fever Blisters
Y N Hepatitis
Y N Pacemaker
Y N Headaches
Y N Migraines
Y N Shingles
Y N Heart Attack
Y N HIV +/ AIDS
Y N Psychiatric Care

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.

_____

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: _____

_____

_____