ORTHODONTIC HARMONY CHILD/TEEN PATIENT INFORMATION

PATIENT NAME_____
First MI Last

Gender____ DOB_____ Age____ School_____ Grade_____

Home address_____
Street City State Zip

Patient's interests_____

How did you hear about us? _____

Who noticed the orthodontic concern? Parent_____ Dentist_____ Other_____

Please describe your concerns _____

_____

FAMILY INFORMATION

Guardian_____**Relationship**_____DOB_____
First MI Last

Cell#(_____)_____ -_____ Carrier_____ Email_____

Home address_____

Employer_____ Work#(_____)_____ -_____Business address_____

Guardian_____**Relationship**_____DOB_____
First MI Last

Cell#(_____)_____ -_____ Carrier_____ Email_____

Home address_____

Employer_____ Work#(_____)_____ -_____Business address_____

Parent's Relationship: Married_____ Separated_____ Divorced_____ Widowed_____ Single_____

Patient Resides with:_____ Both____ Other_____

INSURANCE INFORMATION

Responsible Party_____
First MI Last

DOB_____ Home phone#(_____)_____-_____ Insurance Company _____

Subscriber ID _____ Group ID _____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the person responsible for payment of all fees incurred. for your convenience, we will gladly assist you in submitting your insurance claim by providing you with the necessary orthodontic form, filling in our part, and mailing it for you.

Responsible Party Signature_____ Date_____

Welcome to our practice! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

CHILD MEDICAL HISTORY

Physician's Name_____Address_____Phone_____

Is your child currently taking any medications?	O Yes O No	List:
Is your child allergic to any medications?	O Yes O No	List:
Does your child have any other allergies?	O Yes O No	List:
Has your child's tonsils or adenoids been removed?	O Yes O No	When:

Please check if you have had any of the following conditions:

AIDS/HIV	O Yes O No	Growth Disorders	O Yes O No	Prone to colds	O Yes O No
Anemia	O Yes O No	Heart Condition	O Yes O No	Prone to ear infection	O Yes O No
Asthma	O Yes O No	Heart Murmur	O Yes O No	Prone to sore throats	O Yes O No
Bone Disorder	O Yes O No	Hearing Impaired	O Yes O No	Prolonged Bleeding	O Yes O No
Blood Disease	O Yes O No	Hepatitis Type	O Yes O No	Psychiatric Care	O Yes O No
Bronchitis	O Yes O No	Hernia Repair	O Yes O No	Rheumatic Fever	O Yes O No
Cancer	O Yes O No	Herpes/Cold Sores	O Yes O No	Seizures	O Yes O No
Developmental Disorder	O Yes O No	Hives/Rash	O Yes O No	Sinus Trouble	O Yes O No
Diabetes type	O Yes O No	Kidney Disorder	O Yes O No	Tonsilitis	O Yes O No
Dizziness or Fainting	O Yes O No	Latex Allergy	O Yes O No	Trauma to face or jaw	O Yes O No
Emotional Problems	O Yes O No	Latex Sensitive	O Yes O No	Tuberculosis	O Yes O No
Endocrine	O Yes O No	Liver Disorder	O Yes O No	Ulcer	O Yes O No
Epilepsy	O Yes O No	Mouth Breather	O Yes O No	Vertigo	O Yes O No
Facial/Jaw/TMJ Pain	O Yes O No	Mitral Valve Prolapse	O Yes O No	Vision Impaired	O Yes O No
Frequent Headaches	O Yes O No	Nervous/Anxious	O Yes O No	Other:	

Is there any other conditions or concerns that you think we should know about?

DENTAL HISTORY

Dentist's Name_____Address_____Phone_____

Frequency of dental checks: O Every ____months O Only if problem exists O Never Date of last visit_____

Any unfinished care to be completed by dentist?	O Yes O No	Explain:
Any facial or dental injuries?	O Yes O No	Explain:

Any history of thumb or finger sucking?	O Yes O No	Stopped?
Does your child play a musical instrument?	O Yes O No	Which:
Have teeth been removed? (primary or permanent)	O Yes O No	List:
Any previous orthodontic treatment?	O Yes O No	With whom?
Are you satisifed with previous treatment?	O Yes O No	Explain:

Please Check if there is a history of:

O Clenching teeth O Grinding teeth O Jaw joint clicking O Jaw joint soreness O Jaw joint popping O Ringing in the ears

O Headaches (more than normal) O Mouth breathing: O Awake O Asleep O Muscular soreness around the head and neck

Speech problems O Yes O No Explain: _____

Any other information that may be helpful? _____

Parent's Signature_____ Date_____ Reviewed by_____