

Smile! you're at TAN 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.

TODAY'S DATE: _____

1. Tell us about your child

Child's name (Last, First, MI): _____
Nickname: _____ Birthdate: / / Age: _____
SSN: _____ Male Female
Child's home address: _____
City, State, Zip: _____
Child's home phone: _____
Email address: _____
Grade: _____ School: _____
Hobbies or sports: _____
List brothers and sisters (with ages): _____

2. Tell us about you

Name of person accompanying child: _____
Relation: _____
Do you have legal custody of this child? Yes No
Whom may we thank for referring the child? _____
Who is the child's General Dentist? _____
Date of last visit: / /

3. Parent information

MARITAL STATUS:
 Married Single Partnered Separated Divorced Widowed
 MOTHER'S INFORMATION Step Mother Guardian
Name: _____ Birthdate: / /
SSN: _____ DL#: _____
Home phone: _____
Work phone: _____ Ext: _____
Employer: _____
Job title: _____ How long at current job: _____
 FATHER'S INFORMATION Step Father Guardian
Name: _____ Birthdate: / /
SSN: _____ DL#: _____
Home phone: _____
Work phone: _____ Ext: _____
Employer: _____
Job title: _____ How long at current job: _____

4. Person responsible for account

Name: _____
Relation: _____
Billing address: _____
City State Zip: _____
SSN: _____
DL#: _____
Work phone (include ext.): _____
Home phone: _____
Employer: _____

5. Primary Orthodontic Insurance

ORTHODONTIC COVERAGE? Yes No
Insurance company name: _____
Their address: _____
Their phone: _____
Group number (Plan, Local or Policy #): _____
Policy owner's name: _____
Relation: _____
Policy owner's birthdate: _____
ID number: _____
Policy owner's employer: _____
Employer's address: _____
SECONDARY ORTHODONTIC INSURANCE? Yes No
Insurance company name: _____
Their address: _____
Their phone: _____
Group number (Plan, Local or Policy #): _____
Policy owner's name: _____
Relationship to child: _____
Policy owner's birthdate: _____
ID number: _____
Policy owner's employer: _____
Employer's address: _____

Over please!

6. Tell us your concerns

What are the main concerns that you would like orthodontics to accomplish? _____

Has your child ever taken Phen-Fen (Redux or Pondimin)? Yes No
If yes, when? _____

Have there been any injuries to the face, mouth, teeth or chin?
 Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth?
 Yes No

Has your child ever had any pain or tenderness in the jaw joint?
(TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Does your child floss daily? Yes No

Child's Physician: _____

Physician's phone: _____ Date of last visit: / /

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

(Girls) Has menstruation begun? Yes No

Please describe your child's current physical health: _____

Good Fair Poor

Please list all the drugs your child is currently taking: _____

Please list all the drugs or things to which your child is allergic: _____

7. Are there medical problems?

Has your child ever had any of the following medical problems?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to latex/metals | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any hospital stays | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial bones/joints/valves | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital heart defect |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) | |

Please describe any medical problems your child has/had: _____

8. What about these things?

Has your child ever experienced any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching/grinding teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing bottle habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip sucking/biting | <input type="checkbox"/> Y <input type="checkbox"/> N Speech problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb/finger sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue thrust |

Please provide us the name of a neighbor or relative not living with you:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

9. Understanding and authorization

I understand that the information 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. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I authorize the dental staff to perform the necessary dental service my child may need.

Signature of parent or guardian _____

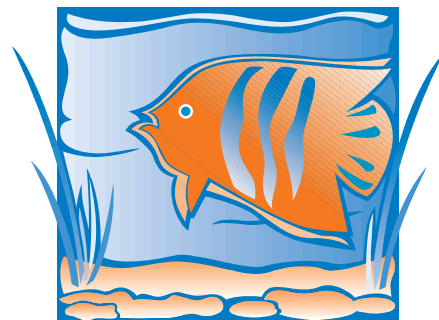
Date _____

If this office accepts insurance, I understand that I'm responsible for payment of services rendered and also responsible for any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature of parent or guardian _____

Date _____

Thank you!



TAN ORTHODONTICS

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