PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date___________________

Patient's name ____
First Middle Last

Address ____
Street City/State Zip

Home Phone (______) ____Gender ______ Female ______Male Age ____________

Nickname__________________________ Birthdate_________________Social Security # ___________________________________

School____Sports/Hobbies _____________________________________

Whom may we thank for referring you to our office? ____

Have any family members been previously treated at our office? ____Yes____ No

Name: _______________________________Name:_____________________________Name:_______________________________

Who is with the child today? ____Relationship________________________________

Do you have custody of this patient? ___Yes___No. If not who does? __________________________ Relationship_______________

Mother's name: ____ Responsible party? _____Yes_____No
First M.I. Last

Cell Phone:(______) ______________________________ Work Phone:(______) ____________________________________

Email Address: ____ Best method of reminders ______Phone_____Text_____Email

Father's name: ____ Responsible party? _____Yes_____No
First M.I. Last

Cell Phone:(_____) _______________________________ Work Phone:(______) ___________________________________

Email Address: ____ Best method of reminders ______Phone_____Text_____Email

RESPONSIBLE PARTY INFORMATION

Name____
First M.I. Last

Address ____
Street City /State Zip

Home phone(______) _________________________________ Work phone(______) ____________________________________

Cell/other phone(______)_______________________________ Email address____

Social Security #______________________________________ Birthdate_________________ Relationship to Patient ____________

Employer____Occupation____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Home address ____
Street City/State Zip

Phone(______)____

CHILD DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security #______________________________

Insurance Company__________________________ Group No._________________ Local No. _________________________________

Insurance Co. Address____ Phone No.________________________________

Do you have Orthodontic coverage? ____Yes___No. If yes what is your benefits? Lifetime maximum:___________________

Deductible__________Amount used____________Payable at what %____________Payments made:______Mthly_____Qtly

Do you have dual coverage? Yes_____ No_____ If yes, add insurance information below:

Insured's Name____ Insured's Social Security #__________________________________

Insurance Company__________________________ Group No._________________ Local No. _________________________________

Insurance Co. Address____ Phone No.________________________________

Do you have Orthodontic coverage? ____Yes___No. If yes what is your benefits? Lifetime maximum:___________________

Deductible__________Amount used____________Payable at what %____________Payments made:______Mthly_____Qtly

I authorize the release of any information related to this claim and hereby assign all benefits to Dr. Ford S. Cooper/OrthoCare.

Signature: ____Date: ____________________

MEDICAL HISTORY

Physician____ Date of Last Visit______________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medications? ____

Yes No Is the patient allergic to any medications? ____

Yes No Is the patient allergic to any foods? ____

Yes No Is the patient allergic to latex? ____

Yes No Is the patient allergic to metals? ____

Yes No Is the patient allergic to acrylic? ____

Yes No Is the patient allergic to any anesthetics? ____

Yes No History of major illness? ____

Yes No Has the patient had any operations? ____

Yes No Ever been involved in a serious accident? ____

Yes No Have seen a physician in the last 12 months?____

Yes No Does patient smoke or chew tobacco? ____

Female Patients only:

Yes No Has menstruation started? When? ____

Yes No Is the patient pregnant? ____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? __________________________

____

CHILD DENTAL HISTORY

General Dentist ____ Date of last cleaning __________________________

What are your chief orthodontic concerns? ____

Has the patient ever seen an orthodontist? If yes, who and when? ____

Yes No Is the patient presently in any dental pain?____

Yes No Ever experienced any unfavorable reaction to dentistry? ____

Yes No Has the patient ever lost or chipped any teeth? ____

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

Yes No Is any part of patient's mouth sensitive to temperature? Where? ___________________________________

Yes No Is any part of patient's mouth sensitive to pressure? Where?______________________________________

Yes No Do gums bleed when brushing? ____

Yes No Any type of thumb or tongue habit? ____

Yes No Is the patient a mouth breather? ____

Yes No Soreness in jaw muscles or face muscles? ____

Yes No Experience jaw clicking or popping?____

Yes No Aware of clenching or grinding teeth during the day? _____________________________________

Yes No Experience "tension" headaches? ____

Yes No Has the patient ever experienced chronic ringing in the ears? ______________________________

Yes No Is the patient sensitive or self-conscious about his/her teeth? ______________________________

Yes No Has patient ever been treated for "TMD' or "TMJ" problems? ______________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strict confidence, and it is my responsibility to inform this office of any changes in my child's medical/dental status.

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 an intricate body part 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 our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I also understand that my picture may be used for social media purposes. In addition, I authorize Dr**.** ___________________________ to perform a complete orthodontic evaluation.

Signature: ____**Date:** ____________________

Office use only

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Staff initials:______

Doctor's signature: ____ Date: ______________________________________

Medical/Dental history update:
1. Date: _______________Signature: ______________________2. Date: ___________________ Signature: _________________

3. Date: _______________Signature: ______________________4. Date: ___________________ Signature: _________________