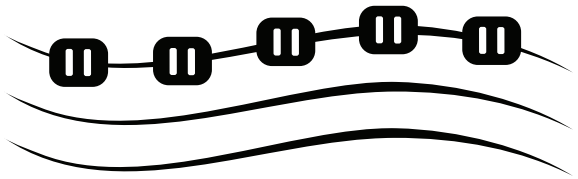

johnson orthodontics

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.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

SS #: _____

Birthdate: _____/_____/_____ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____)_____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

2 Who is accompanying your child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Widowed ☐ Separated

3

☐ **Mother's Information:** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____/_____/_____

E-mail Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____Wk #: (____)_____ Ext: ____

SS #: _____ DL #: _____

☐ **Father's Information:** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____/_____/_____

E-mail Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____Wk #: (____)_____ Ext: ____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: ☐ Mom ☐ Dad ☐ Other

(If other, please complete)

Billing Address: _____

_____
City State Zip

Do you Own or Rent? (circle one) How Long? _____

Hm #: (____)_____ DL #: _____

Cell #: (____)_____ SS #: _____

Employer: _____Wk #: (____)_____ Ext: ____

Who is responsible for making appointments?

Name: _____

Preferred contact number: ☐ Home ☐ Cell ☐ Work

5 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

CONTINUED ON BACK

6

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

_____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) if yes, when? _____

Has your child ever had or been evaluated for or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the Face, mouth, teeth or chin ☐ Yes ☐ No

List any musical instruments played: _____

Have the 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 / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Floss his / her teeth daily? ☐ Yes ☐ No

Child's physician: _____

Phone #: (_____)_____ Date of Last Visit: _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's physical health: ☐ Good ☐ Fair ☐ Poor

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

_____

Please list all of the drugs / things that your child is allergic to: _____

_____

Latex Y N **Metals / Nickel Y N** **Plastics Y N**

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

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergies to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	HIV$^+$ / AIDS
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Lupus
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
			Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

8 Has your child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing / Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biter	Y	N	Tongue Thrust

9 Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 the office, use the services of one or more credit reporting services.

_____
Signature **Date**

I authorize the dental staff to perform any necessary dental services my child may need.

_____
Signature **Date**

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

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

Doctor's Comments: **Initials: _____ Date: _____**

_____

_____

_____