DEFAY orthodontics

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# Child Patient Information

**Patient's Name** _____Preferred Name _____ Sex: ___ M ___ F

Address _____City _____State _____ Zip _____

Birth date _____Age _____ School _____Grade _____

Home Phone (___) _____ Cell (___) _____ **Best** Phone Contact: ____ Home ____ Cell

**Patient's** E-Mail Address (if they want to receive reminders) _____

Child lives with: ___ Both Parents ___ Mother ___ Father ___ Other/Whom: _____

Name of closest relative ***not*** living with you _____ Phone _____ Relationship _____

Names of ***immediate*** family members treated here _____

**If this is your first consult in our office, who referred you or how did you learn about us?** _____

Patient's Dentist _____ City _____

**What is your chief concern with patient's teeth?** _____

**Patient's special interests, talents or hobbies** _____

## Responsible Party Information

**Name of Person responsible for Patient Account** _____Relationship _____

**Father's Name** _____

Employed by _____

Occupation _____

Home Address _____

Cell (___) _____ Business (___) _____

Social Security Number _____-_____-_____

E-Mail _____

Birth date _____

**Mother's Name** _____

Employed by _____

Occupation _____

Business Address _____

Business Phone (___) _____

Social Security Number _____-_____-_____

E-Mail _____

Birth date _____

Parent(s) are/is: ____ Married ____ Separated ____ Divorced ____ Widowed ____ Single

## Orthodontic Insurance Information - If *No* Insurance check here ___

**PRIMARY** Insurance Information:

Name of Insured _____ Relationship to Patient _____

Birth date of Insured _____ Social Security Number _____ - _____ - _____ or I.D. # _____

Employer _____ Business Address _____

Insurance Company _____ Group # _____ Ins. Phone (___) _____

Insurance Address _____ City _____ State _____ Zip _____

Ortho Lifetime Maximum $_____ Used to date $_____ Effective date _____ Called to confirm _____

**SECONDARY** Insurance Information:

Name of Insured _____ Relationship to Patient _____

Birth date of Insured _____ Social Security Number _____ - _____ - _____ or I.D. #_____

Employer _____ Business Address _____

Insurance Company _____ Group # _____ Ins. Phone (___) _____

Insurance Address _____ City _____ State _____ Zip _____

Ortho Lifetime Maximum $_____ Used to date $_____ Effective date _____ Called to confirm_____

# Health and Dental History

Patient's Medical Physician _____ City _____

**Does/Has the Patient:**

| Yes | No | |
|---|---|---|
| ___ | ___ | Have any health problems? Explain _____ |
| ___ | ___ | Take any medications? List _____ |
| ___ | ___ | Have allergic reactions to medications? List _____ |
| ___ | ___ | Currently seeing a physician, other than well child checks? Explain _____ |
| ___ | ___ | Received blood transfusions? Reason _____ |
| ___ | ___ | Had tonsils and adenoids removed? When _____ |
| ___ | ___ | Take medication for immunosuppressive disease? Explain _____ |
| ___ | ___ | Take any medications for dietary conditions? Explain _____ |
| ___ | ___ | Have Hay fever or Seasonal Allergies? Explain _____ |
| ___ | ___ | Have Sinus problems? Explain _____ |

**Has Patient ever had:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Heart Murmur | ___ | ___ | Nervousness/Anxiety | ___ | ___ | Thumb/Finger Sucking |
| ___ | ___ | Rheumatic Fever | ___ | ___ | Emotional/Depression Problem | ___ | ___ | Mouth Breathing |
| ___ | ___ | Heart Surgery | ___ | ___ | Fainting/Dizziness | ___ | ___ | Nail Biting |
| ___ | ___ | High Blood Pressure | ___ | ___ | Epilepsy/Seizures | ___ | ___ | Speech Problems |
| ___ | ___ | Blood/Bleeding Disorder | ___ | ___ | Asthma | ___ | ___ | Teeth Grinding |
| ___ | ___ | Bone Disorder | ___ | ___ | Hives/Rash/Allergic Reaction | ___ | ___ | Teeth Clenching |
| ___ | ___ | Osteoporosis | ___ | ___ | Arthritis/Rheumatism | ___ | ___ | Jaw Popping |
| ___ | ___ | Paget's Disease | ___ | ___ | Cancer | ___ | ___ | Jaw Locking |
| ___ | ___ | Growth Disorder | ___ | ___ | Diabetes | ___ | ___ | Jaw Pain |
| ___ | ___ | Developmental Disorder | ___ | ___ | Kidney Disease | ___ | ___ | Frequent Headaches |
| ___ | ___ | Endocrine Disorder | ___ | ___ | Tuberculosis | ___ | ___ | Ringing in Ears |
| ___ | ___ | Attention Deficit/Hyperactivity | ___ | ___ | Pregnancy (Current/Recent) | ___ | ___ | Pain in Head/Neck |

Other conditions, impairments or problems:_____

**Growth information for patients under 16** – Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to plan our treatment alternatives: Has the patient:

| Yes | No | |
|---|---|---|
| ____ | ____ | Reached puberty? |
| ____ | ____ | Do you feel growth is completed? Patient's Height _____ Father's Height _____ Mother's Height _____ |
| ____ | ____ | Have siblings or parents had orthodontic treatment? |

Frequency of dental checkups: Twice/yr ___ Once/yr ___ Infrequent ___ Never ___ Date of last visit _____

| Yes | No | |
|---|---|---|
| ____ | ____ | Is there any unfinished care to be completed with your dentist? Explain: _____ |
| ____ | ____ | Have you had any unpleasant dental experiences? Explain: _____ |
| ____ | ____ | Are you frightened about orthodontic treatment? Explain: _____ |
| ____ | ____ | Have you had any face or dental injuries? Explain: _____ _____ |
| ____ | ____ | Do you play any musical instrument using the mouth? What Instrument? _____ |
| ____ | ____ | Have you consulted with an orthodontist previously? With Whom? _____ |
| ____ | ____ | Have you had any previous orthodontic treatment? With Whom? _____ |
| ____ | ____ | Are you aware of missing or extra permanent teeth? Explain: _____ |
| ____ | ____ | Are you satisfied with prior orthodontic treatment? Explain: _____ |

Is there any other information that may be helpful? _____

**HIPAA PRIVACY POLICY:** I understand that I have certain rights to privacy in regards to my protected health information. I have had the opportunity to receive, read, and understand this office's Notice of Privacy Policy.

**INSURANCE:** I authorize the release to my insurance company or companies any information, including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

Parent/Guardian's Signature Relationship to Patient Date