WELCOME
TO SCOTT ORTHODONTICS

We would like to welcome you and your child to our office. Our goal is to make your 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.

TELL US ABOUT YOUR CHILD

Today's Date________________ ❒ Male ❒ Female

Child's Name:_______________________________
LAST FIRST MI

Nickname:_______________________________

Child's Birth Date: ____/____/____ Child's Age:______

School:______________________ Grade:________

Hobbies / Sports:_______________________________

Child's Home #:_______________________________

Parent/Guardian Cell#:__________________ Text: ❒ Yes ❒ No

Child's Home Address:_______________________________
APT/CONDO#

____
CITY STATE ZIP

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 and ages:__________________

____

General Dentist:_______________________________

Last Visit Date:_______________________________

Parents' Marital Status: ❒ Single ❒ Widowed ❒ Married ❒ Divorced ❒ Separated

PARENT/GUARDIAN #1 INFORMATION

Relationship to Patient ______________

Name:__________________ Birth Date:____/____/____

Wk#:(___)_________ Ext:_____ Hm#: (___)__________

Employer:_______________________________

How Long at Current Job:______ Job Title:__________

SS#________________ DL#:________________

PARENT/GUARDIAN #2 INFORMATION

Relationship to Patient ______________

Name:__________________ Birth Date:____/____/____

Wk#:(___)_________ Ext:_____ Hm#: (___)__________

Employer:_______________________________

How Long at Current Job:______ Job Title:__________

SS#________________ DL#:________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:____________________ Relation:__________

Billing Address: _______________________________

____
CITY STATE ZIP

Previous Address: _______________________________

____
CITY STATE ZIP

Hm#: (___)______________ DL#:______________

Employer:_______________________________

Wk#:(___)_________ Ext:_____ SS#: __________

E-Mail: _______________________________

WHO WILL BE MAKING APPOINTMENTS?

Name:_______________________________

Wk#:(___)_________ Ext:_____ Hm#: (___)__________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❒ Yes ❒ No ❒ Not Sure

Insurance Co. Name:_______________________________

Insurance Co. Address:_______________________________

Insurance Co. Phone #: (___)__________________

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

Policy Owner's Name:_______________________________

Relationship to Patient:_______________________________

Policy Owner's Birth Date:___/___/___SS#:__________

Policy Owner's Employer:_______________________________

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❒ Yes ❒ No ❒ Not Sure

Insurance Co. Name:_______________________________

Insurance Co. Address:_______________________________

Insurance Co. Phone #: (___)__________________

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

Policy Owner's Name:_______________________________

Relationship to Patient:_______________________________

Policy Owner's Birth Date:___/___/___SS#:__________

Policy Owner's Employer:_______________________________

CONTINUED ON BACK

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

____
____
____

Has your child ever 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 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

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

Please list all drugs that your child is currently taking:

____

Please list all drugs that your child is allergic to:

____
____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N	Abnormal Bleeding	Y N	Diabetes
Y N	Allergy to any Drugs	Y N	Handicaps / Disabilities
Y N	Allergy to Latex / Metals	Y N	Hearing Impairment
Y N	Allergy to Plastic	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia
Y N	Any Operations	Y N	Hepatitis
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Cancer	Y N	Kidney / Liver Problems
Y N	Congenital Heart Defect	Y N	Rheumatic / Scarlet Fever
Y N	Convulsions / Epilepsy	Y N	Tuberculosis (TB)

Please Discuss any medical problems that your child has had:

____
____
____

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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 Biting	Y N	Tongue Thrust

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name:____________________ Phone:(___)__________

Address: ______________________________________

____
CITY STATE ZIP

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

____
Signature **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____
Signature of parent or guardian **Date**

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

Doctors' Comments: Initials: __________ Date:______________

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