LAFAYETTE ORTHODONTICS

Welcome to our office!

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

About Your Child

Patient's Name:_____
Nickname: _____
Birthdate:____/_____/_____ ☐ **Male** ☐ **Female**
Home Address:_____
_____
Phone: (____)_____
Email:_____
School:_____ **Grade:**_____
Hobbies/Sports:_____
Please list any family members we have seen:_____
_____

General Info

Who is accompanying the child today?
Name:_____ Relation:_____
Do you have legal custody of this child? ☐Yes ☐No
Whom may we thank for referring you?
_____
Do You Know Any of Our Patients?_____
_____
Other siblings/ages:_____
_____

Parent Info

Marital Status: □ Single □ Married □ Widowed □ Divorced
Responsible Party:_____
Mother's Name:_____
Address: (If different than patient's)_____
_____
_____
SS#: _____ **Wk #:** (____)_____
Cell #:(____)_____ **Carrier:**_____
Email:_____
Employer:_____ **Occupation:**_____
Father's Name:_____
Address: (If different than patient's)_____
_____
_____
SS#: _____ **Wk #:** (____)_____
Cell #:(____)_____ **Carrier:**_____
Email:_____
Employer:_____ **Occupation:**_____

Insurance Info

If you have Orthodontic Insurance Coverage for the patient, please fill out below:

Insurance Co. Name: _____
Insurance Address: _____
_____
Insurance Phone: (____)_____
Insured's ID#:_____
Group# (Plan, Local, or Policy #): _____

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. 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian _____ Date _____

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Medical History

Has your child experienced the following medical problems?

☐Y ☐N Abnormal Bleeding
☐Y ☐N ADD/ADHD
☐Y ☐N AIDS/HIV+
☐Y ☐N Hospital Stays/ Operations
☐Y ☐N Artificial Bones/ Joints/Valves
☐Y ☐N Asthma
☐Y ☐N Cancer
☐Y ☐N Congenital Heart Defect
☐Y ☐N Convulsions
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Murmur
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis
☐Y ☐N Kidney Problems
☐Y ☐N Liver Problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Prosthetics
☐Y ☐N Rheumatic Fever
☐Y ☐N Scarlet Fever
☐Y ☐N Sickle Cell Disease/ Traits
☐Y ☐N Tuberculosis (TB)
☐Y ☐N Handicaps/ Disabilities

Is your child currently under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

Has menstruation begun? ☐Y ☐N

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

_____

☐Y ☐N Latex **☐Y ☐N Nickel/Metals** **☐Y ☐N Plastic**

Dental History

General Dentist: _____

Last visit date:_____

Has your child ever been evaluated or had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Does your child require antibiotics before dental treatment? ☐Y ☐N

Have adenoids or tonsils been removed? ☐Y ☐N

Does your child have any missing or extra permanent teeth? ☐Y ☐N

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐Y ☐N

Does your child brush his/her teeth daily? ☐Y ☐N

Floss his/her teeth daily? ☐Y ☐N

Does/did your child experience any of the following?

☐Y ☐N Ice Chewing
☐Y ☐N Clenching/Grinding Teeth
☐Y ☐N Lip Sucking/Biting
☐Y ☐N Mouth Breather
☐Y ☐N Nail Biting
☐Y ☐N Nursing Bottle Habits
☐Y ☐N Speech Problems
☐Y ☐N Thumb/Finger Sucking
☐Y ☐N Tongue Thrust
☐Y ☐N Used Pacifier
☐Y ☐N Snoring

List any musical instruments played:_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian: _____ Date _____