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WELCOME

We would like to welcome you and your child to our office.
Our goal is to make every child's visit pleasant and educational.

1 Tell Us About Your Child

Today's date: ___________________________

Child's Name: ___________________________
Last First M.I.

Name Preferred: ________________ ☐ Male ☐ Female

Child's Birthdate: ___ / ___ / ___ Age: ________________

School: ________________ Grade: ________________

Hobbies: ___________________________

Siblings' Names: ___________________________

Child's Home Address: ___________________________

City: ________________ State: __________ Zip: ________

2 Who is Accompanying the Child Today

Name: ___________________________

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

Who may we **Thank** for referring you? ________________

Other family members seen by us: ________________

____

3 Mother's Information

☐ Mother ☐ Stepmother
☐ Guardian

Name: ___________________________

Work #: ________________ Ext: ________________

Home #: ________________ Cell #: ________________

Employer: ___________________________

Occupation: ___________________________

Father's Information

☐ Father ☐ Stepfather
☐ Guardian

Name: ________________ Cell #: ________________

Employer: ___________________________

Occupation: ___________________________

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated
☐ Single ☐ Widowed

4 Person Responsible for Account

Name: ________________ Relation: ________________

Billing Address : ___________________________

____
City State Zip

Work #: __________ Ext. #: __________ Cell #: __________

Employer: ___________________________

Date of birth: ___ / ___ / ___

________________ ________________
Signature of Responsible Party Date

5 Primary Dental Insurance

Insurance Co. Name: ___________________________

Insurance Co. Address: ___________________________

____

Insurance Co. Phone #: ___________________________

Group #: ________________ ID #: ________________

Subscriber's Name: ________________ Relation: __________

Subscriber's Birthdate: ___ / ___ / ___ S.S #: ________________

Subscriber's Employer: ___________________________

I certify that I am covered by insurance with ________________

________________ , and assign directly to Kelley Orthodontics
(name of insurance company(ies)
all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

________________ ________________
SIGNATURE DATE

6 Dental History

What concerns you most about your child's teeth/bite?

____

Has your child ever had a serious/difficult problem associated with previous dental work? □ No □ Yes

Has your child ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? □ No □ Yes

How many times does your child brush daily? ______________________

How many times does your child floss weekly? ______________________

Does your child use an electric toothbrush? _____What Brand? ___________

Does your child require any pre-medication (antibiotics) prior to dental work?

□ No □ Yes

Child's dentist: ____

Date of last dental visit: ______________________________________

7 Emergency Contact

Name of nearest relative not living with you

Name: ____________________________ Relation: ___________________

Cell #: _____________________________ Home #: ___________________

8 Medical History

Physician's Name: ____

Physician's Phone #: _________________________

Describe your child's current physical health:

□ Good □ Fair □ Poor

Please list all drugs that the child is currently taking: ___________________

____

Is your child allergic to any medication? □ No □ Yes

Does the child have any of the following habits?

Y N Mouth Breather
Y N Tongue Thrust
Y N Speech Habits
Y N Thumb/Finger Sucking
Y N Grinding
Y N Nail Biting

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

Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV + / AIDS
Y N Hemophilia
Y N Asthma/Allergies
Y N Hepatitis
Y N Tuberculosis (TB)
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations
Y N Any stays in a hospital
Y N Kidney/Liver problems
Y N Handicaps/Disabilities
Y N Sleep Apnea

Comments: ____

____

____

Are there any health issues we should be aware of?

____

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

9

I understand 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 medical status.

Office Use Only

I verbally reviewed the medical/dental information above with the patient herein. TX Coord: _____________ Date: ______________

Comments: ____

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