South Bay Orthodontics

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SouthBayOrthodontics.com

Tell Us About Your Child

Today's Date: _____ Gender: _____

Child's Name: _____
Last First M

Nickname: _____

Child's Home Address: _____
Apt #

_____
City State Zip

Child's Home #: _____

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Whom may we Thank for referring you? _____

List brothers/sisters with age:

_____

_____

Were they treated by this office? _____

GENERAL DENTIST: _____

Address: _____

Town: _____

Phone #: _____

Last Visit Date: _____

Primary Orthodontic Insurance

Orthodontic Coverage? ❒ Yes ❒ No Dental Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's SS#/ID#: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

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

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

Parent #1 Information: ❒ Parent ❒ Step-parent ❒ Guardian

Name: _____ Birthdate: _____

Home #: _____ Work #: _____

Cell #: _____ SS#: _____

Address: **(if different than patient)** _____

_____

Email: _____

Employer _____

Job Title _____

Parent #2 Information: ❒ Parent ❒ Step-parent ❒ Guardian

Name: _____ Birthdate: _____

Home #: _____ Work #: _____

Cell #: _____ SS#: _____

Address: **(if different than patient)** _____

_____

Email: _____

Employer _____

Job Title _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❒ Yes ❒ No Dental Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's SS#/ID#: _____

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

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

Has puberty begun? ❒ Yes ❒ No

(Girls) Has menstruation begun? ❒ Yes ❒ No

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

Please list all drugs that your child is currently taking:

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

Do we have your permission to display your child's before and after pictures on our bulletin board?
❒ Yes ❒ No

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

Doctor's Comments:

Initials: Date:

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

❒ Y	❒ N	Abnormal Bleeding	❒ 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	Allergic 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:

Has your child ever had 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

Authorization

I certify that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment, with my informed consent.

Signature: Date:

HIPAA Acknowledgement

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. I understand that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature:
Patient, parent or legal guardian

Date:

If signed by a patient representative, state relationship to patient: