WELCOME TO

milde FAMILY ORTHODONTICS

Tell Us About Your Child

Today's Date: ______

Child's Name: ______
LAST FIRST MI

Nickname: ______ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: ____

School: ______ Grade: ____

Hobbies/Sports: ______

Child's Home Address ______

______
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 w/ages: ______

______

______

General Dentist? ______

Last Visit Date: ______

Parent Information

Mother's Name: ______

☐ Step Mother ☐ Guardian

Work Phone ______ Ext. ______

Home Phone ______

Employer: ______

Father's Name: ______

☐ Step Father ☐ Guardian

Work Phone ______ Ext. ______

Home Phone ______

Employer: ______

Person Responsible for Account

Name: ______ Relation: ______

Billing Address: ______

______
CITY STATE ZIP

Work Phone ______ Ext. ______

Home Phone ______

Employer: ______

DL#: ______

Who is responsible for making payments?

Name: ______

Work Phone ______ Ext. ______

Home Phone ______

Primary Orthodontic Insurance

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______

Insurance Co. Address: ______

Insurance Co. Phone #: ______

Group # (Plan, Local or Policy #) ______

Insured's Name: ______

Relationship to Patient: ______

Insured's Birthdate: ____/____/____ SS# (If Delta Dental): ______

Insured's Employer: ______

Secondary Orthodontic Insurance

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______

Insurance Co. Address: ______

Insurance Co. Phone #: ______

Group # (Plan, Local or Policy #) ______

Insured's Name: ______

Relationship to Patient: ______

Insured's Birthdate: ____/____/____ SS# (If Delta Dental): ______

Insured's Employer: ______

CONTINUED ON BACK OF FORM

What are your main orthodontic concerns and treatment goals?

____

____

Has your child ever been evaluated or had orthodontic treatment?

☐ Yes ☐ No

Has there been any injury to the face, mouth, teeth or chin?

☐ Yes ☐ No

List any musical instruments played _______________

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Are you aware of any missing or extra permanent teeth in your child's mouth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness or clicking in his/her jaw (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** Allergic to Plastic
Y **N** Heart Murmur
Y **N** Damaged Heart Valves
Y **N** Cancer
Y **N** Diabetes
Y **N** Rheumatic Fever
Y **N** HIV+/AIDS
Y **N** Hemophilia
Y **N** Asthma
Y **N** Hepatitis
Y **N** Tuberculosis (TB)
Y **N** Allergic to Latex/Metals
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** Developmental Disabilities
Y **N** Allergies to any Drugs

Please discuss any medical problems that your child has ever had:

____

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____

____

Does your child have any of the following?

Y **N** Thumb/Finger Sucking
Y **N** Lip Sucking/Biting
Y **N** Clenching/Grinding Teeth
Y **N** Nursing Bottle Habits
Y **N** Mouth Breather
Y **N** Speech Problems
Y **N** Nail Biting
Y **N** Tongue Thrust

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I have reviewed the medical history for my son/daughter_______________and certify that it is accurate and that there have been no changes since the date of the last signature.

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.

____

Signature of parent or guardian Date Signature of parent of guardian Date

____

Signature of parent or guardian Date Signature of parent of guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials_______ Date______________

Doctor's Comments: _______________________________

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