

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you and your child.

PATIENT INFORMATION

Name _____ Gender: Female or Male
Address _____
City _____ State _____ Zip _____ Phone _____
Birth Date _____ Social Security # _____ School _____ Grade _____
Family members with previous orthodontic treatment _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home _____ Work _____

RESPONSIBLE PARTY INFORMATION

Father _____ Birth Date _____
Address _____
Previous Address if less than 1 Yr. _____
Home Phone _____ Social Security # _____ Driver's License #/State _____
Employer _____ Work Phone _____ Cell Phone _____
Occupation _____ Years Employed _____

Mother _____ Birth Date _____
Address _____
Previous Address if less than 1 Yr. _____
Home Phone _____ Social Security # _____ Driver's License #/State _____
Employer _____ Work Phone _____ Cell Phone _____
Occupation _____ Years Employed _____

DENTAL HISTORY

General Dentist _____ Date of last dental check-up? _____
Why are you interested in orthodontic treatment for your child? _____
Has your child ever had orthodontic treatment or been evaluated for orthodontic treatment? Yes _____ No _____
Does your child have any jaw related discomfort? _____
Has your child ever experienced a mouth or chin injury? _____
Does your child have any habits/problems affecting the mouth or teeth? (Nail-biting/Thumb or Finger sucking etc.) _____
Does your child breathe through his/her mouth while awake? _____ Asleep? _____

Has your child ever experienced an adverse reaction in conjunction with a medical/dental procedure? _____

Other information about your child's dental health or any previous treatment _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? If yes, describe _____

Is your child currently under physician care? Yes ___ No ___ Describe _____

Have the child's adenoids or tonsils been removed? Yes ___ No ___

Check if your child has had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Allergy to Drugs/Medicines | <input type="checkbox"/> Describe _____ |
| <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergy to Materials | <input type="checkbox"/> High Blood Pressure |
| (latex, metal, chemicals) _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mitral Valve problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Nervous problems |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pacemaker/ Heart Surgery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Rheumatic/ Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia-Abnormal Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis |

List medications your child is taking: _____

Does your child have any conditions that require premedication prior to any dental procedures? _____

AUTHORIZATION

- I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.
- I authorize all insurance benefits otherwise payable to me for services rendered, to be paid to Drs. Toothman & Barra, P.A. (if applicable).
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

- I understand that, with in house financing, credit bureau reports may be obtained.
- I also give my approval and consent for my child's name and/or photograph to be used in scientific and/or promotional work produced by Drs. Toothman & Barra, P.A. and their staff.

Signature _____ Date _____

INSURANCE

To be filled out by patient:

PRIMARY DENTAL INSURANCE

Subscriber Name _____
 Relation _____ Birth Date _____ Social Security # _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____
 Subscriber Employed By _____ Occupation _____
 Business Address _____
 Business Phone _____
 Insurance Company _____ Phone _____
 Insurance Address _____
 Contract # _____ Group # _____ Subscriber # _____
 Name of other dependents under this plan _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional orthodontic insurance? _____
 Subscriber Name _____ Relation to Patient _____ Birth Date _____
 Address _____
 City _____ State _____ Zip _____
 Social Security # _____
 Subscriber Employed By _____ Business Phone _____
 Insurance Company _____ Phone _____
 Insurance Address _____
 Contract # _____ Group # _____ Subscriber # _____
 Name of other dependents under this plan _____

Please bring your insurance card so that we may obtain a copy.