Please Complete Both Sides and Bring to Your Child's Appointment. Thank You.

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orthodontics for children & adults

1814 S. Rochester Rd
Rochester Hills, MI 48307
248.608.2626

Patient Information

CHILD'S FULL NAME: ______________________________ SEX: M ....: ....6=FH<85H9 ____________

CHILD LIVES WITH: **Both Parents........Acl\Yf.........:Uh\Yf........; iUfX]Ub**

Father's Information

Full Name: ______________________________
Home Address: ______________________________
City, State Zip: ______________________________
Home Phone: ______________________________
Cell: ______________________________
eMail: ______________________________
Employed By: ______________________________
Employer Phone Number: ______________________________
Occupation: ______________________________
Social Security #: ______________________________
Date of Birth: ______________________________
Dental Insurance Co: ______________________________
Insurance Phone #: ______________________________
Group #: ______________________________
Subscriber ID/Contract #: ______________________________

Mother's Information

Full Name: ______________________________
Home Address: ______________________________
City, State Zip: ______________________________
Home Phone: ______________________________
Cell: ______________________________
eMail: ______________________________
Employed By: ______________________________
Employer Phone Number: ______________________________
Occupation: ______________________________
Social Security #: ______________________________
Date of Birth: ______________________________
Dental Insurance Co: ______________________________
Insurance Phone #: ______________________________
Group #: ______________________________
Subscriber ID/Contract #: ______________________________

Other Insurance Coverage Information

Insured Party's Name: ______________________________
Employer: ______________________________
Group #: ____________ Subscriber ID #: ____________
Relationship to Child: ______________________________
Insurance Co: ______________________________
Insurance Phone #: ______________________________

Alternate Number - Emergency

(Friend, neighbor, relative, etc.)

Name: ____________________ Relationship to Child: ____________________ Phone: ____________

Referral Source

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: ______________________________ Relationship: ____________________

Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.

Please be as complete as possible

Family Physician or Pediatrician: ______________________________

Specialists: ______________________________

Medical History

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS or HIV Positive			Counseling			Kidney Disorder		
Allergies o LATEX o MEDICINE			Cystic Fibrosis			Muscular Dystrophy		
Arthritis			Developmental Challenges			Motor Skills Delayed		
Artificial Prosthesis/Joints/Pins			Diabetes			Reflux		
Asperger Syndrome			Down Syndrome			Shunt		
Asthma			Eating Disorder			Speech Delayed		
Attention Deficit Disorder/Hyperactivity			Epilepsy/Seizures			Surgery		
Autism Spectrum Disorder			Hearing Impaired/Deafness			Thyroid Problems		
Blood Disorder/Anemia			Heart Disorder/Surgery			Vision Impaired/Blindness		
Cancer			Hepatitis/Liver Disorder			Other		
Cerebral Palsy			Infectious Disease (MRSA, TB, other)			Other		

Please explain any YES answers ______________________________

or other health problems: ______________________________

Is your child: 1. Allergic to Penicillin Erythromycin Ceclor Sulfa Tree Nuts Other ______________

2. Taking any medicine now? YES NO Explain: ______________

3. At the appropriate grade level for his/her age? YES NO Explain: ______________

Is there any other issue we should know to help us better relate to your child? YES NO If yes, explain below:

____

Dental History

Any previous dental experience? YES NO Where: ______________

What was done: ______________ When: ______________

Child's reaction: ______________ Parent's reaction: ______________

Main dental concerns: ______________

Has your child ever had injuries to the head or neck? YES NO Explain: ______________

Does/did your child have any oral habits? Thumb Finger Pacifier Other______________

Names and ages of other children in the household: ______________

Dietary History

Does your child snack frequently? YES NO On what? ______________

Does/did your child take a bottle to bed? YES NO Explain: ______________

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature: ______________________________ Date: ______________

(Parent/Guardian)