

WELCOME TO



UNIVERSITY ORTHODONTICS

Please fill out this form completely; it is important to your child's orthodontic care. Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

Today's Date: _____

Tell Us About Your Child:

Child's Name: _____
LAST FIRST MI
 Nickname: _____ M F
 Birthdate: ___/___/___ Age: _____ SS #: _____
 School: _____ Grade: _____
 Hobbies/Sports: _____
 Child's Home # (_____) _____
 Child's Home Address: _____
 E-mail Address: _____

Person Responsible for Account:

Name: _____ Relation: _____
 Billing Address: _____
CITY STATE ZIP
 Wk #: (____) _____ Hm # (____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____ Birthdate: ___/___/___

Who is responsible for making appointments?

Name: _____
 Wk #: (____) _____ Hm # (____) _____

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 other family members seen by us _____
 General Dentist: _____
 Date of last cleaning/visit: _____
 Parent's Marital Status: _____

Primary Orthodontic Insurance

Orthodontic Coverage? yes no
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: (____) _____
 Group # (plan, local or policy #): _____
 Policy Owner's Name: _____
 Relationship to patient: _____
 Policy Owner's Birthdate: ___/___/___
 Policy Owner's ID #: _____
 Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? yes no
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: (____) _____
 Group # (plan, local or policy #): _____
 Policy Owner's Name: _____
 Relationship to patient: _____
 Policy Owner's Birthdate: ___/___/___
 Policy Owner's ID #: _____
 Policy Owner's Employer: _____

Parental Information:

Mother Stepmother Guardian other _____
 Name: _____ Birthdate: ___/___/___
 Wk #: (____) _____ Hm # (____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____
 Father Stepfather Guardian other _____
 Name: _____ Birthdate: ___/___/___
 Wk #: (____) _____ Hm # (____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____
 Relationship: _____
 Wk #: (____) _____ Hm # (____) _____

OFFICE USE ONLY

Insurance Pre-authorization: _____

Child's Medical/Dental History

What would you like orthodontics to accomplish? _____

Has your child ever been evaluated or had orthodontic treatment before? YES NO

Have there been any injuries to the face, mouth, teeth, or chin? YES NO (if yes, please circle which one)

Have adenoids or tonsils been removed? YES NO (if yes, please circle which one)

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

Has your child had any speech problems? YES NO

Does your child breathe through their mouth? While awake While asleep

Is your child under the care of a physician? YES NO

Child's Physician: _____ Phone # (____) _____ Date of last visit: _____

Please describe your child's current physical health: Good Fair Poor

Are the child's immunizations current? YES NO

Has puberty begun? YES NO

Girls- Has menstruation begun? YES NO (if yes, when: _____)

Please list all drugs that your child is currently taking and why: _____

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

Allergic to the following: Latex YES NO Metals/Nickel YES NO Plastics YES NO

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

Y N Abnormal Bleeding	Y N Convulsions/ Epilepsy
Y N ADD/ ADHD	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 Artificial Bones/ Joints	Y N HIV+/AIDS
Y N Artificial Valves	Y N Kidney/ Liver Problems
Y N Asthma	Y N Lupus
Y N Cancer	Y N Rheumatic/Scarlet Fever
Y N Congenital Heart Defect	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

Has your child ever experienced any of the following?

Y N Clenching/ Grinding Teeth	Y N Nursing/Bottle Habits
Y N Lip Sucking/ Biting	Y N Thumb/Finger Sucking
Y N Nail Biting	Y N Tongue Thrust

Do they like their smile? YES NO

If not, what would you change? _____

Would you like to discuss anything with the Doctor in private? YES NO

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

SIGNATURE OF PARENT OR GUARDIAN

DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

SIGNATURE OF PARENT OR GUARDIAN

DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

SIGNATURE OF PARENT OR GUARDIAN

DATE

OFFICE USE ONLY

Doctor's
Comments: _____
