webb ORTHODONTICS

Child Information Form
Date: _____

WELCOME!

To assist us in providing the most complete service, please provide the following information and health history.

Patient Name (First, Middle, Last)_____ Nickname_____

Birth Date _____ Age _____ Gender: **M** or **F** School _____

Grade_____ Adopted? **Y** or **N** -- At What Age? _____ Brothers/Sisters (Name and age)_____

Dentist_____ Physician_____

Who should we thank for referring you? _____

Parent 1 – Mother / Father / Guardian

Name_____

Address_____

City/State/Zip_____

E-mail _____ Best Phone_____

Employer_____

Policy Owner's DOB _____ SS# _____

Marital Status:

O Single O Married O Separated O Divorced O Widowed

Parent 2 – Mother / Father / Guardian / None

Name_____

Address_____

City/State/Zip_____

E-mail _____ Best Phone_____

Employer_____

Policy Owner's DOB _____ SS# _____

Marital Status:

O Single O Married O Separated O Divorced O Widowed

Person financially responsible for the account: _____

Signature: _____ **Date:** _____

Primary Dental Insurance Only

Orthodontic Coverage? □ Yes □ No

If "Yes" please complete below:

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insurance ID # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's DOB_____ SS# _____

Policy Owner's Employer _____

FOR OFFICE USE ONLY:

____% _____ Age ____ Max _____ How much met? _____

WPE: **Y** or **N** Waiting: **Y** or **N**

Insurance Verification: **Submit** OR **Auto**

Date_____ Effective Date_____ Ded _____

How to bill: Mos_____ Qtr_____ 6 Mos _____ Annual _____

Payer ID _____ Carrier # _____

Medical History

0 Adenoids Removed	0 Anemia
0 Asthma	0 Bone Disorders
0 Birth Abnormalities	0 Diabetes
0 Faintness/Dizziness	0 Epilepsy
0 Earaches	0 Joint Swelling
0 Hepatitis	0 Heart Trouble
0 Emotional Problems	0 Tonsils Removed
0 Endocrine Problems	0 Tonsillitis
0 Sore Throats	0 Prolonged Bleeding
0 Thyroid Problems	0 Rheumatic fever
0 Positive HIV Test	0 Kidney or Liver Disease

List any other serious illnesses:

_____

Allergies to: Latex/Metal/Drugs/Local Anesthetics (circle)

Other Allergies: _____

Current Drugs/Medications_____

Dental History

0 Any Thumb/Finger sucking habits? 0 Past 0 Present 0 None

0 Any injuries to face, mouth, teeth? (circle)

0 Mouth-breathing when awake, asleep? (circle)

0 More than average amount of decay/cavities?

0 Any missing permanent teeth? _____

0 Any extra permanent teeth? _____

0 Any teeth removed by extraction? _____

0 Is there any tongue-thrusting issues?

0 Any speech difficulties? _____

0 Any difficulty swallowing or chewing?

0 Any pain or clicking on opening/closing mouth? (circle)

0 Does patient visit dentist regularly? Recent Date_____

0 Any previous orthodontic treatment/consultation? (circle)

Reason_____

Currently Under Physician's Care? 0 Yes 0 No

Physician_____ Reason _____

Comments _____

OTHER INFORMATION

Patient's Attitude Towards Treatment (Circle One)

Wants it Done Today! Does Not Care Not too Thrilled…

What is Your Biggest Concern?

_____

_____

_____

Sports or Physical Activities _____

Any Wind Instruments played _____

Approximately how much has the patient grown in the last year? _____

If female, has the patient had her first menstrual cycle?

0 Yes 0 No If so, when was it? _____

*This aids us in predicting growth

Any Other Important Information

_____

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and 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 I may need during diagnosis and treatment with my informed consent.

X _____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 the office, use the services of one or more credit reporting services.

X _____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.

X _____Date_____