GeorgeOrthodontics
more than beautiful smiles

Child Patient Information

Patient's Name _____Today's Date _____

Mailing Address _____ City _____ State _____ Zip _____

Birth Date____/_____/_____ Age_____ ❑M ❑F Grade _____ School_____

Dentist _____ Date of Last Dental Check Up _____

Whom may we thank for referring you to our office?_____

Email address:_____

Responsible Party Information

Father's Name _____ ❑Single ❑Married ❑Divorced ❑Separated

Address _____ City _____ State _____ Zip _____ Yrs _____

Home Phone _____Work Phone _____ Cell Phone_____

Social Security Number _____- _____-_____ Birth Date _____/_____/_____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Mother's Name _____❑Single ❑Married ❑Divorced ❑Separated

Address _____ City _____ State _____ Zip _____ Yrs _____

Home Phone _____Work Phone _____ Cell Phone_____

Social Security Number _____- _____-_____ Birth Date _____/_____/_____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____

Insurance Company _____ ID No. _____ Group No. _____

Insurance Co Address _____City _____ State _____ Zip _____

Phone _____

2nd Insured's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____

Insurance Company _____ ID No. _____ Group No. _____

Insurance Co Address _____City _____ State _____ Zip _____

Phone _____

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.

Emergency Contact Information

Name of nearest relative not living with you:_____Phone:_____

Please continue on back of page

Dental History

What is your main concern? _____

_____

Are you interested in: (Please indicate all that apply)

❑ Information ❑ Treatment now ❑Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? ❑ Yes ❑ No
2. Does the patient have any speech problems? ❑ Yes ❑ No
3. Has the patient ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
4. Has any previous orthodontic treatment been rendered? ❑ Yes ❑ No
5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.? ❑ Yes ❑ No
6. Have you ever observed your child has any habits? ❑ Thumb/finger sucking ❑ Mouth breathing ❑Tongue thrust

Other:_____

Medical History

Name of your physician _____ Date of last exam_____

1. Is the patient in good health? ❑Yes ❑No
2. Does the patient have a health problem? ❑Yes ❑No If yes, explain_____
3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)?
   ❑Yes ❑No If yes, please list: _____
4. Please list any current prescription medications: _____
5. Has the patient had any recent rapid growth ❑Yes ❑No ❑Early? ❑Late? Females: Has menstruation begun? ❑Yes ❑ No
   If yes, when? _____ Pregnant? ❑Yes ❑ No
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

❑ Problems at Birth	❑ Hepatitis/Liver Disease	❑ Seizures
❑ Heart Disease/Murmur	❑ Tuberculosis	❑ Cleft Lip/Palate
❑ Rheumatic Fever	❑ Kidney Disease	❑ Speech or Hearing Problems
❑ Sickle Cell Anemia	❑ Cancer/Radiation Therapy	❑ Tonsil, Adenoid, Sinus Problems
❑ Anemia/Hemophilia	❑ Cerebral Palsy	❑ Emotional/Behavior Problems
❑ Diabetes	❑ Arthritis	❑ Learning Disabilities
❑ AIDS or HIV	❑ Asthma	❑ Growth Problems

Other:_____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any *changes*. 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.

_____ _____

Responsible party signature Date

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