Welcome to Children's Dental World

Please take a few minutes to complete the following form to help us better understand your orthodontic needs. All information you provide is confidential.

Your Name: _______________________________

Home Address: ____________________________

City: ________________ Postal Code: __________

Home Phone: _____________________________

Cell Phone: ______________________________

Work Phone: ______________________________

Birth date: (M/D/Y) ___/___/____ Sex: M F

Dentist: _________________________________

Email: ___________________________________

Emergency Contact: _________________________

Relationship: ______________________________

Phone Number:_____________________________

Who can we thank for sending you to our office?

☐ Referred by dentist

☐ Referred by family/friend

☐ Saw office in area

☐ Radio ☐ T.V commercial ☐ Website

☐ Other: ___________________________________

Do you have a dental plan that covers orthodontic treatment? ☐ Yes ☐ No

Primary Insurance

Name of Insurance Company: ____

Group Number: ________________________ Contract Number: _____________________________________

Name of Subscriber: ______________________________________ Birth date: (M/D/Y) ____/____/_________

Secondary Insurance

Name of Insurance Company: ____

Group Number: ________________________ Contract Number: _____________________________________

Name of Subscriber: ______________________________________ Birth date: (M/D/Y) ____/____/_________

A dental insurance plan is a contract between you and your insurance company. It is the policy of this office to bill and receive payment directly from our patients for services rendered. We will gladly assist you in preparing your claims to submit to your insurance company for reimbursement.

Medical Information

Physician's Name: _________________________________ Date of last exam: (D/M/Y) _____/_____/_____

Have you ever been diagnosed with any of the following conditions? (Please check):

Does your child have or ever been diagnosed with any of the following conditions (please check):

__AIDS/HIV	__Cancer	__Hepatitis	__Tuberculosis
__ADD/ADHD	__Cerebral Palsy	__Kidney Disease	
__Allergies	__Cleft Lip/Palate	__Liver Disease	
__Anemia	__Diabetes	__Mentally Challenged	
__Asthma	__Epilepsy	__Rheumatic/Scarlet Fever	
__Autism	__Eye Problems	__Seizures	
__Bleeding Disorder	__Heart Disease/Murmur		

Please describe any other medical issues (medication, illnesses, surgery) if not listed above:

____

____

Orthodontic Concerns

Reason for seeking an orthodontic consultation: ____

Do you have any concerns with the way your teeth look? ☐ Yes ☐ No

If yes, how would you like them changed?

____

Do you have any concerns about how you bite? ☐ Yes ☐ No

If yes, please tell us what you see as the problem:

____

Do you have any concerns about the facial appearance/profile? ☐ Yes ☐ No

If yes, what you like to be different?

____

Have you ever experienced any of the following habits/conditions (Please check):

☐ Previous ortho consultation/treatment ☐ Clenching/grinding ☐ Dental or facial pain

☐ Difficulty chewing, swallowing, eating, breathing ☐ Thumb or finger sucking habit

☐ Frequent headaches ☐ Trauma to any teeth or jaw ☐ TMJ pain, clicking, noises, or locking

☐ Speech problems Any other problems? ____

I certify that I have read and understand the above questions. If I had any questions about this form, they were answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in completing this form.

____

Patient Signature Date