Welcome

to the Orthodontist

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

1. Tell Us About Your Child

Today's Date:_____ Child's Name: _____

Nickname:_____ ☐Male ☐Female Birthdate:_____ Age:_____ SS#:_____

School:_____ Grade: _____ Child's Home #: (__)_____

Hobbies/Sports:_____ E-mail Address:_____

Childs Home Address:_____

2. Parental Information

☐ Mother ☐Stepmother ☐Guardian

Name: _____ Birthdate:_____Work #: (__)_____ Home #: (__)_____

Employer:_____ Job Title: _____ How long have you been there? _____

SS#:_____ DL#: _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____ Birthdate:_____ Work #: (__)_____Home #: (__)_____

Employer:_____ Job Title:_____ How long have you been there?_____

SS#:_____ DL#: _____

Who is Accompanying your Child today? _____Relation:_____

Person responsible for Account:_____ Who referred you? _____

3. Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No Insurance Co. Name: _____

Insurance Co. Phone #: (__)_____ Policy Owner's Name: _____

Relationship to Patient:_____ Policy Owner's Birthdate: _____ SSN#: _____

Please give your Insurance card to the receptionist for a copy, thank you!

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 that 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 my child may need during diagnosis and treatment. 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.
I will accept responsibility for any bill incurred for Orthodontic treatment.

Signature _____ Date: _____

4. Patient's Health History

Patient Dentist:_____ Phone #: ( )_____ Last Cleaning: _____

Has the patient had previous orthodontic consultations? ☐ Yes ☐ No Treatment? ☐ Yes ☐ No

If so please list where:_____

Present Drugs/Medications:_____

_____

List any allergies or drug sensitivity:_____

_____

What are the main concerns that you would like orthodontics to accomplish?_____

_____

_____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No (Redux or Pondimin) If yes, When? _____

_____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____ Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? _____

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No Does your child floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician:_____ Phone #: ( )_____

Date of last visit:_____ Is your child under the care of a physician? ☐ Yes ☐ No

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

5. Have you ever had any of the following Diseases/ Medical problems:

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding/Hemophilia	☐	☐	Convulsions / Epilepsy
☐	☐	ADD/ ADHD	☐	☐	Diabetes
☐	☐	Allergies to Any drugs	☐	☐	Handicaps / Disabilities
☐	☐	Allergic to Latex / Metals	☐	☐	Hearing Impairment
☐	☐	Allergic to Plastic	☐	☐	Heart Murmur
☐	☐	Any hospital stays	☐	☐	Hemophilia
☐	☐	Any operations	☐	☐	Hepatitis
☐	☐	Artificial Bones/Joints /Valves	☐	☐	HIV + / AIDS
☐	☐	Asthma	☐	☐	Kidney / Liver Problems
☐	☐	Cancer	☐	☐	Lupus
☐	☐	Congenital Heart Defect	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Tuberculosis (TB)			

Please list any serious medical condition(s) that you have ever had:

_____

_____

6. Has your child ever experienced any of the following?

Yes	No		Yes	No	
☐	☐	Clenching / Grinding Teeth	☐	☐	Nursing/ Bottle Habits
☐	☐	Lip Sucking / Biting	☐	☐	Speech Problems
☐	☐	Mouth breather	☐	☐	Thumb / Finger sucking
☐	☐	Nail Biting	☐	☐	Tongue Thrust

★ Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and ADA.

Neighbor or Relative not living with you:

Name: _____ Phone #: ( )_____

Address: _____

_____

Thank you for visiting the office of Dr. Guajardo it was a pleasure seeing you and your child and we look forward to seeing you again!