

**Child Patient Information (Please Print)**

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Father/ Guardian \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Responsible Party**

Name: \_\_\_\_\_

Employed By: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip Code

Employer's Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

**Medical History**

**Please Check**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you in good health?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have regular medical examinations?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any history of heart trouble, allergies, diabetes, asthma, hepatitis, kidney, or liver involvement, epilepsy, or bleeding disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a cerebral or spastic condition or mental imbalance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever experienced any unfavorable reaction to medicine, Such as: penicillin, aspirin, or novocaine? (Please specify in line 10)          | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you taking any drugs or medication regularly? (Specify in line 10)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Who is your Medical Doctor? _____ Phone: _____   |                          |                          |
| 8. Who is your Dentist? _____ Phone: _____  |                          |                          |
| 9. Have you ever had orthodontic treatment in the past? _____   |                          |                          |
| 10. Is there anything we should know about you that would adversely affect orthodontic treatment?   |                          |                          |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Dental Insurance Only**

***Primary Insurance***

Dental Coverage  Yes  No

Orthodontic Coverage  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Owner's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Social Security # or Subscriber ID #: \_\_\_\_\_

Policy Owner's Employer's Name: \_\_\_\_\_

***Secondary Insurance***

Dental Coverage  Yes  No

Orthodontic Coverage  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Owner's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Social Security # or Subscriber ID #: \_\_\_\_\_

Policy Owner's Employer's Name: \_\_\_\_\_

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverages. Signature provides authorization for credit bureau check.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_