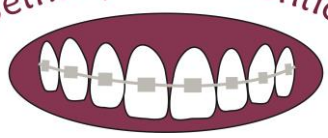
Welcome

Bethany Orthodontics



1 About Your Child

Today's Date_____ Nickname_____

Child's Name_____

Date of Birth_____ ___M, ___F

School_____ Grade_____

Hobbies/Sports_____

Child's Home #_____

Phone # to Confirm Appointment_____

Contact Person to Confirm Appointment_____

Child's Home Address_____

_____

General Dentist_____

Phone_____ Last Visit Date_____

What are the main concerns for this orthodontic consultation?

_____

2 Who is Accompanying Your Child today?

Name_____ Relation_____

Who may we thank for referring you?

___Dentist, ___Friend name_____

___Google, ___Invisalign, ___Yelp, Other_____

___Insurance, ___Magazine

___Sign on the Street, ___Concert, ___School Carnival

3 Mother's Information

___Step Mother, __Guardian

Name_____

Work #_____ Home #_____

Father's Information

___Step Father, __Guardian

Name_____

Work #_____ Home #_____

Parent's Marital Status ___Married, __Divorced, ___Separated

4 Primary Responsible Party

Name_____ Relation_____

Billing Address_____

_____

Home #_____ Work #_____

5 Primary Orthodontic Insurance

Insurance Co. Name_____

Phone #_____

Claim Address_____

Policy Owner's Name_____

Employer_____ Group #_____

ID or SSN_____ Date of Birth_____

Secondary Orthodontic Insurance

Insurance Co. Name_____

Phone #_____

Claim Address_____

Policy Owner's Name_____

Employer_____ Group #_____

ID or SSN_____ Date of Birth_____

By signing below, you agree to authorize the orthodontist to release any information from the diagnosis and records to any third party dental insurance group you belong to with the benefits payable to the orthodontist for treatment rendered within the office.

Signature_____ Date_____

6 Dental History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

__Teeth Grinding or Clenching
__Sore and or tender Jaws
__History of TMJ problems
__Gum disease
__Bleeding gums
__Fear of dental treatment
__Sore teeth
__Sensitive teeth
__Mouth breathing
__Mouth blistering or ulcers
__Finger or lip sucking
__Tongue thrusting habit
__Gag easily
__Bad Breath

Brush teeth daily __Y, __N Floss teeth daily __Y, __N

__Prior orthodontic treatment, explain_____

__Prior oral surgery, explain_____

__Other, explain_____

7 Current Medications

Child's Physician_____
Phone_____

Please list all current medications and the medical conditions for its use_____

8 Medical History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

__High blood pressure
__Chest Pains
__Stroke
__Rheumatic Fever
__Shortness of Breath
__Heart Trouble or Murmur
__Prosthetic Device
Need antibiotics before dental treatment __Y, __N
__Lung disease
__Asthma
__Allergy to Latex
__Other allergy or hay fever, explain_____
__Sinus Problem
__Ulcers or stomach problems
__Diabetes
__Hepatitis or liver disease
__Kidney disease
__Thyroid trouble
__Sexually transmitted disease
__Arthritis
__Cancer
__Bruise easily, prolonged bleeding
__Glaucoma
__Epilepsy
__Psychiatric therapy
__Exposed to HIV
__HIV or AIDS
__Possibly pregnant
__Take birth control pills
__Joint disease
__Other, explain_____

__None of the above

9 I understand that the information that I have given is correct, and it is my responsibility to inform this office of any changes in my child's dental and medical status, and medications. I authorize the orthodontist and staff to perform the services for my child.

Signature_____ Date_____

10 I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my orthodontic insurance does not cover.

Signature_____ Date_____