



UNDER 18

NAME \_\_\_\_\_ Prefers to be called \_\_\_\_\_ Sex \_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_

Child's Hm. Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Child's Hm. phone \_\_\_\_\_

Child lives with: Both parents \_\_\_ Mother \_\_\_ Father \_\_\_ Other \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_

E-mail (to confirm appts) \_\_\_\_\_

Favorite School Subjects \_\_\_\_\_ What is the quality of their school work? A \_\_\_ B \_\_\_ C \_\_\_ D \_\_\_ F \_\_\_

Hobbies/Sports/Musical Instruments \_\_\_\_\_

Please list brothers/sisters with age: \_\_\_\_\_

Has anyone in the family had braces/Invisalign? \_\_\_ Who? \_\_\_\_\_ Were you/they pleased with the results? \_\_\_

Who is accompanying your child today? \_\_\_\_\_ Relation \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ General Dentist \_\_\_\_\_

How often does your child see the dentist? \_\_\_\_\_ Date of last dental exam(MM/YY) \_\_\_/\_\_\_

What are the main concerns that you would like orthodontics to address? \_\_\_\_\_

Has your child been evaluated for or had orthodontic treatment before? When? \_\_\_/\_\_\_ Where? \_\_\_\_\_ Y N

Is your child self-conscious of his/her teeth? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Have you been informed that he/she is missing or has extra permanent teeth? Y N

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ) or face? Y N

Does your child have any dental problems at this time (pain, cavities, etc.)? Y N

Does your child have a fear of dentists? Y N

Does he/she have to be reminded to brush the teeth daily? Y N

Please explain any 'Y' answers above \_\_\_\_\_

**Airway:** Please circle if: adenoids / tonsils / or both / have been removed? When? \_\_\_/\_\_\_ Y N

Do they snore when sleeping? If so, please circle one. Nightly / Frequently / Occasionally Y N

Does your child have or have they had any of the following **tendencies or habits**?

Breathe through mouth when awake Y N Thumb/finger sucking Y N

Sleep with their lips apart Y N Speech problems Y N

Clenching/grinding teeth - awake Y N Tongue thrust Y N

Clenching/grinding teeth - sleeping Y N Smoke or chew tobacco Y N

Please explain any 'Y' answers above \_\_\_\_\_

**MEDICAL INFORMATION** Child's Physician: \_\_\_\_\_

**Did/does your child have:**

Any health problems Y N Substance abuse problem Y N

Ever have to be hospitalized Y N Psychiatric counseling Y N

Abnormal delivery as infant Y N Frequent or severe headaches Y N

Asthma/respiratory problems Y N Epilepsy/seizures Y N

Heart Murmur, heart disease, Y N Sensory or Anxiety issues Y N

Diabetes Y N Lip or inside mouth lesions (sores) Y N

Cancer, radiation or chemotherapy Y N **Allergies:** Penicillin allergy Y N

Prolonged bleeding or Anemia Y N Latex, vinyl, or acrylic allergy Y N

Bone fractures, any major accidents Y N Nickel or other metal allergy Y N

Thyroid or other hormone therapy Y N Other allergies: \_\_\_\_\_

Please explain any 'Y' answers or list any health concerns not addressed above: \_\_\_\_\_

**Some medications can affect tooth movement.** Please list any medications your child is taking and the condition for which the medication was prescribed: \_\_\_\_\_

**Growth, maturation and genetic tendencies play an important role in determining the most opportune time to begin orthodontic treatment.** The following information is requested to assist us in evaluating jaw/overall growth potential:

**Has your child:(If male)** had voice changes? **Y N** **When?** \_\_\_/\_\_\_ **(If female)** begun menstruation? **Y N** **When?** \_\_\_/\_\_\_

Child's height : \_\_\_\_\_ Biological father's height: \_\_\_\_\_ Biological mother's height: \_\_\_\_\_ **OVER>>>>**

PATIENT'S NAME \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Biological**  **Adoptive**  **Stepmother**  **Guardian**

Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Biological**  **Adoptive**  **Stepfather**  **Guardian**

Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Patient's biological parents:**  Married  Divorced  Mother remarried  Father remarried  Separated  Widowed (N/A if patient adopted)

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS: \_\_\_\_\_

WE WILL ASK WHOEVER IS GIVING CONSENT FOR ORTHODONTIC TREATMENT TO SIGN THE FINANCIAL AGREEMENT AND BE RESPONSIBLE FOR PAYMENT OF THE ACCOUNT. ANY ARRANGEMENTS FOR A THIRD PARTY PAYMENT WILL BE AN AGREEMENT BETWEEN THE FINANCIALLY RESPONSIBLE PARTY AND THE THIRD PARTY.

**PRIMARY ORTHODONTIC INSURANCE: IF YOU WISH TO HAVE OUR OFFICE SUBMIT YOUR INSURANCE, PLEASE COMPLETELY FILL OUT THE INSURANCE SECTION.**

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's employer \_\_\_\_\_ Insured's birthdate \_\_\_\_\_

**SECONDARY ORTHODONTIC INSURANCE:**

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's employer \_\_\_\_\_ Insured's birthdate \_\_\_\_\_

**I authorize the release of information relating to orthodontic claims. I understand that I am responsible for all costs of treatment.**

**I hereby authorize payment directly to F. Richard Beckwith, DDS insurance benefits otherwise payable to me.**

**X**

**X**

\_\_\_\_\_  
Signed (Patient, or parent if minor)      Date

\_\_\_\_\_  
Signed (insured person)      Date

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 it is my responsibility to inform this office of any changes in my child's medical status.

Signature

Date