Welcome To Santa Rosa Orthodontics

We would like to welcome you and your child to our office. Our Goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Date: _____
Nickname: _____
Child's name: _____
Birthdate: _____/_____/_____ Age: _____
Child's home address: _____
_____
Gender: _____
Phone number:_____
School:_____
Sports/hobbies: _____
Email address: _____

Who Is Accompanying Your Child Today?

Name:_____ _Relation:_____
Do you have legal custody of this child? Y____ N____
Whom may we thank for referring you?_____
Other events you have seen us: _____Sports Team
_____Schools
_____Community Events _____Website _____Other

Please Specify:_____
List brothers/sisters with age:_____
General Dentist: _____
Last Visit Date: _____
Parents Marital Status: _____
Spouse Name:_____
Spouse Employer:_____ Job Title: _____

Person Responsible For Account

Name:_____ Relation:_____
Billing
Address:_____
_____
Years at current address: _____ Rent:_____ Own:_____
Hm #_____Wk# _____Ext._____
Employer:_____
How long at current job: _____
Job Title:_____
SS#: _____ Birthdate:___/___/_____

Who is Responsible for Making Appointments?

Name: _____ Birthdate: __/__/____
Wk# _____ Ext.__ Hm# _____

Primary Orthodontic Insurance

Orthodontic Coverage? Yes__ No__

Name:_____
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Group #: _____
Policy Owner's Name: _____
_____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___
ID# _____
Policy Owner's Employer: _____
_____

Secondary Orthodontic Coverage

Name:_____
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Group #: _____
Policy Owner's Name: _____
_____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___
ID#: _____
Policy Owner's Employer: _____
_____

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

_____

Has your child ever taken Phen-Fen? (Also known as Redux or Pondimin)
Yes___ No___

If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? **Yes___ No___**

Have there been any injuries to the face, mouth 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 permanent teeth? **Yes___ No___**

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___**

Floss his/her teeth daily? **Yes___ No ___**

Child's physician: _____

Phone #: _____

Date of last Visit: _____

Is your child currently under the care of a physician? **Yes____No ___**

Has Puberty begun? **Yes___ No___**

Has Menstruation begun? (Girls) **Yes___ No____**

Please describe your child's current physical health:
Good _____ Fair____ Poor____

Please list all drugs your child is currently taking:

_____

Please list all drugs/things your child is allergic to:

_____

_____

Y N Latex **Y N** Metals/Nickel **Y N** Plastics

Y N Abnormal bleeding
Y N ADD/ADHD
Y N Allergic to Plastic
Y N Artificial Bones /Joints /Valves?
Y N Cancer
Y N Diabetes
Y N Hearing Impaired
Y N Hemophilia
Y N Kidney/Liver Problems
Y N Tuberculosis
Y N Convulsions/ Epilepsy
Y N Allergies to any Drugs
Y N Allergic to Latex/ Metals
Y N Any Hospital Stays
Y N Asthma
Y N Congenital Heart Defect
Y N Handicaps/Disabilities
Y N Heart Murmur
Y N HIV+/ AIDS
Y N Lupus
Y N Rheumatic/ Scarlet Fever

Please discuss any medical problems your child has had:

_____

_____

_____

_____

_____

Has your child ever had any of the following?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/ Bitting
Y N Mouth Breather
Y N Nail Bitting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Neighbor or Relative not living with you:

Name:_____

Phone:_____

Address:_____

_____

City State Zip

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also understand that for training purposes only, this office may occasionally film their office and clinical procedures. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent/guardian **Date**

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 this office, use the services of one or more credit reporting services

_____

Signature of parent/guardian **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment of the group insurance benefits directly to this office.

_____

Signature of parent/guardian **Date**

OFFICE USE ONLY **OFFICE USE ONLY** **OFFICE USE ONLY** **OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's comments: **Initials:_____Date:_____**

_____

_____