Anderson Orthodontics

Robert E. Anderson, D.D.S.

Specialist in Orthodontics

Child's Information

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

Email Address: _____ SS #: _____

Birthdate: _____/_____/_____ Age: _____ ❑ Male ❑ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (_____) _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

❑ **Mother's Information** ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____/_____/_____

Email Address: _____

Cell #: (_____)_____ Home #: (_____)_____

Employer: _____ Wk #: (_____) _____

SS #: _____ DL #: _____

❑ **Father's Information** ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____/_____/_____

Email Address: _____

Cell #: (_____)_____ Home #: (_____)_____

Employer: _____ Wk #: (_____) _____

SS #: _____ DL #: _____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____
APT/CONDO #

_____
CITY STATE ZIP

Hm #(_____)_____ DL #: _____

Cell #(_____)_____ SS #: _____

Employer: _____ Wk #: (____)_____ Ext: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext: ___ Hm #: (_____) _____

Primary Orthodontic Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Continued on back

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, 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?
❑ 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 that your child is currently taking: _____

_____

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

_____

Latex ❑ Yes ❑ No Metals/Nickel ❑ Yes ❑ No Plastics ❑ Yes ❑ No

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. **I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.**

_____

Signature of Parent or Guardian Date

Has your child ever had any of the following medical problems?

Yes	No		Yes	No	
❑	❑	Abnormal Bleeding	❑	❑	Diabetes
❑	❑	ADD / ADHD	❑	❑	Handicaps / Disabilities
❑	❑	Allergies to any Drugs	❑	❑	Hearing Impairment
❑	❑	Allergic to Latex / Metals	❑	❑	Heart Murmur
❑	❑	Allergic to Plastics	❑	❑	Hemophilia
❑	❑	Any Hospital Stays	❑	❑	Hepatitis
❑	❑	Any Operations	❑	❑	HIV+ / AIDS
❑	❑	Artificial Bones / Joints / Valves	❑	❑	Kidney / Liver Problems
❑	❑	Asthma	❑	❑	Lupus
❑	❑	Cancer	❑	❑	Rheumatic / Scarlet Fever
❑	❑	Congenital Heart Defect	❑	❑	Tuberculosis (TB)
❑	❑	Convulsions / Epilepsy			

Please discuss any medical problems that your child has had:

_____

_____

_____

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

Neighbor or Relative not living with you.

Name_____Phone(_____)_____

Address _____
APT/CONDO #

_____
CITY STATE ZIP

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 or 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 hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

Initials: _____ Date: _____

I verbally reviewed the medical / dental information above with the Parent / Guardian and Patient named herein.

Doctor's Comments: _____

_____

_____