FOR CHILDREN: WELCOME TO OUR PRACTICE

Date: ______________ OPMS#: ______________
Doctor: CY D S P
Location: J F M P B
Exam With: ______________

PATIENT INFORMATION

PATIENT NAME: ______________ DOB: ______________ AGE: ______

PREFERRED NAME: ______________ MALE ❑ FEMALE ❑

ADDRESS: ______________ PHONE: (____)__________ CELL: (____)__________

CITY: ______________ STATE: ______ ZIP: ______ SCHOOL: ______________ GRADE: ______

HOBBIES/SPECIAL INTERESTS: ______________

NAME OF GENERAL DENTIST: ______________ PHONE : (______)______________

NAME OF OTHER FAMILY MEMBERS TREATED HERE: ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________

FATHER'S INFORMATION

NAME: ______________

BIRTHDAY: ______________ SS#: ______________

ADDRESS: ______________

EMAIL: ______________

PHONE: (____) ______________

CELL: (____) ______________

EMPLOYER: ______________

MARITAL STATUS: ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

❑ OTHER ______________

SPOUSE: ______________

MOTHER'S INFORMATION

NAME: ______________

BIRTHDAY: ______________ SS#: ______________

ADDRESS: ______________

EMAIL: ______________

PHONE: (____) ______________

CELL: (____) ______________

EMPLOYER: ______________

MARITAL STATUS: ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

❑ OTHER ______________

SPOUSE: ______________

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? ______________

____

HAS THE CHILD EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH DENTAL WORK? __ ❑ YES ❑ NO

HAVE THE TONSILS/ADENOIDS BEEN REMOVED? ______________ ❑ YES ❑ NO

IS THE CHILD'S WATER FLUORIDATED? ______________ ❑ YES ❑ NO

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS? ______________ ❑ YES ❑ NO

HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? ______________ ❑ YES ❑ NO

DOES THE CHILD BRUSH TEETH DAILY? ______________ ❑ YES ❑ NO

FLOSS THEIR TEETH DAILY? ______________ ❑ YES ❑ NO

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? ______________ ❑ YES ❑ NO

EXPLAIN: ______________

CHILD'S PHYSICIAN: ______________

PHONE: (____) ______________ LAST VISIT: ______________

PLEASE DESCRIBE THE CHILD'S HEALTH: ______________ ❑ GOOD ❑ FAIR ❑ POOR

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING: ______________

____

PLEASE LIST ALL DRUGS THE CHILD IS ALLERGIC TO: ______________

____

YES	NO		YES	NO	
❑	❑	HEART MURMUR	❑	❑	ADD OR ADHD
❑	❑	CANCER	❑	❑	CONGENITAL HEART DEFECT
❑	❑	DIABETES	❑	❑	CONVULSIONS/EPILEPSY
❑	❑	RHEUMATIC FEVER	❑	❑	ABNORMAL BLEEDING
❑	❑	HIV+/AIDS	❑	❑	HEARING IMPAIRMENT
❑	❑	HEMOPHILIA	❑	❑	ANY OPERATIONS
❑	❑	ASTHMA	❑	❑	ANY STAYS IN HOSPITAL
❑	❑	HEPATITIS	❑	❑	KIDNEY/LIVER PROBLEMS
❑	❑	TUBERCULOSIS	❑	❑	HANDICAPS/DISABILITIES
❑	❑	PROSTHESIS	❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	ALLERGIC TO LATEX & METAL	❑	❑	HISTORY OF SCARLET FEVER

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT THE CHILD HAS HAD: ______

____

____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

YES	NO		YES	NO	
❑	❑	THUMB SUCKING / FINGER SUCKING	❑	❑	NAIL BITING
❑	❑	LIP SUCKING / BITING	❑	❑	NURSING BOTTLE HABITS

I understand the information that I have given is correct to the best of my knowledge, that it 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 of parent/guardian ______________ Date: ______________

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: ______________________

INSURANCE PHONE: ______________________

GROUP/POLICY #: ______________________

INSURED'S NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

INSURED'S DOB: ______________________

SS#/ID#: ______________________

INSURED'S EMPLOYER: ______________________

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: ______________________

INSURANCE PHONE: ______________________

GROUP/POLICY #: ______________________

INSURED'S NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

INSURED'S DOB: ______________________

SS#/ID#: ______________________

INSURED'S EMPLOYER: ______________________

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. SIGNATURE OF PARENT/GUARDIAN: ______________ DATE: ______________

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. SIGNATURE OF PARENT/GUARDIAN: ______________ DATE: ______________

OFFICE USE ONLY

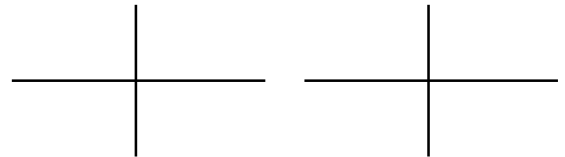
PROFILE	MANDIBLE	SYMMETRY	LIPS AT REST	FACIAL HEIGHT
115 convex	118 mesognathic	000 symmetrical	058 together	121 normal
116 concave	119 retrognathic	039 mandible to RT	059 apart	122 short
117 straight	120 prognatic	039 mandible to LT	060 trapped	123 long

MOLAR CLASS	CROWDING	SPACING	MAX MIDLINE	MAND MIDLINE
001 Class I	007 none upper	005 upper	000 normal	000 normal
002 Class II div 1 RL	008 none lower	019 diastema	040 to RT	042 to RT
003 Class II div 2 RL	015 upper sl mod sev	006 lower	041 to LT	043 to LT
004 Class III	015 lower sl mod sev			

TMJ SYMPTOMS	MANDIBULAR MOVEMENT	PERIO	RANGE OF OPENING
051 none R,L	036 mod 1-3mm	064 healthy	110 normal ________ mm
360 neg/bad test	037 excess 4-6mm	055 gingivitis	111 limited ________ mm
062 click/pop R,L	038 severe 7+	057 recession	
opening, closing, lateral	039 end-end	056 periodontitis	
055 crepitus R,L			
056 condylar pain R,L			
057 muscle pain			

DENTAL LEVEL 000 primary 000 secondary 000 mixed

TEETH PRESENT: **TEETH MISSING:**



OVERBITE	OVERJET	CROSSBITE	ENAMEL DEFECTS
025 mod 25-75%	036 mod 1-3mm	026 anterior cross	096 decalcification
022 deep 75-100%	037 excess 4-6mm	shape	097 defects
021 100% +	038 severe 7+	028 posterior	098 attrition
024 openbite	039 end-end	029 max buccal	379 abfractions
027 edge-edge			

COMMENTS: ______________________