PATIENT FORM (CHILD)

Hamilton, Wilson & Hendrickson ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible!

PATIENT INFORMATION

Name _____ Nickname _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Sex ☐ M ☐ F ☐ OTHER E-mail _____ Birthdate _____
MM/DD/YY

Primary Phone _____ School _____ Grade _____

Sports/Musical Instruments: _____

Siblings _____
PLEASE LIST NAMES AND DATES OF BIRTH

Dentist _____ Last Visited _____

How did you hear about our practice? ☐ ADVERTISEMENT ☐ FAMILY/FRIEND ☐ INTERNET ☐ DENTIST ☐ OTHER

Relatives treated by us: _____ Who referred you to us? _____

PARENT/GUARDIAN CONTACT INFORMATION ☐ MOTHER ☐ FATHER ☐ STEP-MOTHER ☐ STEP-FATHER ☐ GUARDIAN

Name _____ Sex ☐ M ☐ F ☐ OTHER
LAST FIRST MIDDLE

Address _____
(If different than the child's) STREET CITY STATE ZIP

Marital Status _____ Birth Date _____ E-mail _____
MM/DD/YY

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

PARENT/GUARDIAN CONTACT INFORMATION ☐ MOTHER ☐ FATHER ☐ STEP-MOTHER ☐ STEP-FATHER ☐ GUARDIAN

Name _____ Sex ☐ M ☐ F ☐ OTHER
LAST FIRST MIDDLE

Address _____
(If different than the child's) STREET CITY STATE ZIP

Marital Status _____ Birth Date _____ E-mail _____
MM/DD/YY

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

EMERGENCY CONTACT INFORMATION

Name _____
LAST FIRST MIDDLE

Primary Phone _____ E-mail _____

DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

MEDICAL AND DENTAL HISTORY

Is your child currently being treated by a physician? ☐ YES ☐ NO If yes, explain: _____

Physician _____ Phone _____ Last Visit _____

What are your main concerns that you would like orthodontics to accomplish?

_____

_____

Has your child ever been evaluated for orthodontic treatment? ☐ YES ☐ NO If yes, explain: _____

Has puberty and/or menstruation begun? ☐ YES ☐ NO

Is your child pregnant? ☐ YES ☐ NO Is your child nursing? ☐ YES ☐ NO Is your child taking birth control pills? ☐ YES ☐ NO

Have your child's tonsils or adenoids been removed? ☐ YES ☐ NO Has your child ever experienced jaw joint pain (TMJ/TMD)? ☐ YES ☐ NO

MEDICAL AND DENTAL HISTORY CONTINUED

Does your child have speech problems? ☐ YES ☐ NO **If yes, explain:** _____

Do your child's gums bleed? ☐ YES ☐ NO **Does your child like their smile?** ☐ YES ☐ NO

Has your child ever had injury to: ☐ TEETH ☐ MOUTH ☐ CHIN **If yes, explain:** _____

Does your child have any have any missing or extra permanent teeth? ☐ YES ☐ NO

Has your child ever taken any drugs referred to as FenPhen, Redux, or Pondimin? ☐ YES ☐ NO

Does your child smoke or use electronic cigarettes? ☐ YES ☐ NO

Does your child have any of the following habits?

☐ LIP SUCKING/BITING ☐ PROLONGED BOTTLE/PACIFIER ☐ MOUTH BREATHER ☐ THUMB/FINGER SUCKING
☐ NAIL BITING ☐ CLENCHING/GRINDING TEETH ☐ TONGUE THRUSTING ☐ CHEWING/EATING PROBLEM

Is your child allergic to any of the following?

☐ METALS/PLASTICS ☐ DENTAL ANESTHETICS ☐ LATEX ☐ OTHER

List all the drugs your child is currently taking: This would include prescriptions, diet, or over-the-counter medications. Please include the dosage.

_____

_____

Please describe any serious medical condition(s): This would include any allergies, serious illnesses, operations, hospitalizations, or surgeries.

_____

_____

Has your child ever had any of the following?

☐ ADD/ADHD
☐ ABNORMAL BLEEDING
☐ ANEMIA
☐ ARTIFICIAL BONES/JOINTS/VALVES
☐ ASTHMA
☐ ARTHRITIS
☐ BACK PROBLEMS
☐ BLOOD DISEASE
☐ BLOOD TRANSFUSION
☐ CANCER/CHEMOTHERAPY
☐ CHEMICAL DEPENDENCY
☐ CIRCULATORY PROBLEMS
☐ CONGENITAL HEART DEFECT
☐ CORTISONE TREATMENTS
☐ PERSISTENT COUGH
☐ COUGHING BLOOD
☐ DIABETES
☐ DIFFICULTY BREATHING
☐ EPILEPSY/SEIZURES/FAINTING
☐ FEVER BLISTERS/HERPES
☐ GLAUCOMA
☐ HEART ATTACK/STROKE
☐ HEART MURMUR
☐ HEART SURGERY/PACEMAKER
☐ HEMOPHILIA
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV+/AIDS
☐ JAW PAIN
☐ KIDNEY PROBLEMS
☐ LIVER DISEASE
☐ MISTRAL VALVE PROLAPSE
☐ PSYCHIATRIC PROBLEMS
☐ RADIATION TREATMENT
☐ RESPIRATORY DISEASE
☐ RHEUMATIC/SCARLET FEVER
☐ RHEUMATISM
☐ SEVERE/FREQUENT HEADACHES
☐ SHORTNESS OF BREATH
☐ SICKLE CELL DISEASE/TRAITS
☐ SINUS PROBLEMS
☐ SKIN RASH
☐ SWELLING OF FEET OR ANKLES
☐ THYROID PROBLEMS
☐ TOBACCO HABIT
☐ TONSILLITIS
☐ TUBERCULOSIS
☐ ULCERS/COLITIS
☐ VENEREAL DISEASE

SIGNATURE

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

I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by _____ **Date** _____