

# Welcome

Bethany Orthodontics



## 1 About Your Child

Today's Date \_\_\_\_\_ Nickname \_\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ M, \_\_\_ F

School \_\_\_\_\_ Grade \_\_\_\_\_

Hobbies/Sports \_\_\_\_\_

Child's Home # \_\_\_\_\_

Phone # to Confirm Appointment \_\_\_\_\_

Contact Person to Confirm Appointment \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
\_\_\_\_\_

General Dentist \_\_\_\_\_

Phone \_\_\_\_\_ Last Visit Date \_\_\_\_\_

What are the main concerns for this orthodontic consultation?  
\_\_\_\_\_

## 2 Who is Accompanying Your Child today?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Who may we Thank for referring you?

\_\_\_ Dentist, \_\_\_ Friend name \_\_\_\_\_, \_\_\_ Insurance

\_\_\_ Internet Listing \_\_\_\_\_, \_\_\_ Mailing Brochure

\_\_\_ Phone Book/Qwest, \_\_\_ Phone Book/Verizon

\_\_\_ School Carnival, \_\_\_ Concert, \_\_\_ Sign on the Street

## 3 Mother's Information \_\_\_\_\_ Step Mother, \_\_\_ Guardian

Name \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Father's Information \_\_\_\_\_ Step Father, \_\_\_ Guardian

Name \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Parent's Marital Status \_\_\_ Married, \_\_\_ Divorced, \_\_\_ Separated

## 4 Primary Responsible Party

Name \_\_\_\_\_ Relation \_\_\_\_\_

Billing Address \_\_\_\_\_  
\_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

## Secondary Responsible Party

Name \_\_\_\_\_ Relation \_\_\_\_\_

Billing Address \_\_\_\_\_  
\_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

## 5 Primary Orthodontic Insurance

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

Phone # \_\_\_\_\_

Claim Address \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

ID or SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Secondary Orthodontic Insurance

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

Phone # \_\_\_\_\_

Claim Address \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

ID or SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

By signing below, you agree to authorize the orthodontist to release any information from the diagnosis and records to any third party dental insurance group you belong to with the benefits payable to the orthodontist for treatment rendered within the office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## 6 Dental History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

- Teeth Grinding or Clenching
  - Sore and or tender Jaws
  - History of TMJ problems
  - Gum disease
  - Bleeding gums
  - Fear of dental treatment
  - Sore teeth
  - Sensitive teeth
  - Mouth breathing
  - Mouth blistering or ulcers
  - Finger or lip sucking
  - Tongue thrusting habit
  - Gag easily
  - Bad Breath
- Brush teeth daily \_\_Y, \_\_N      Floss teeth daily \_\_Y, \_\_N
- Prior orthodontic treatment, explain \_\_\_\_\_
- Prior oral surgery, explain \_\_\_\_\_
- Other, explain \_\_\_\_\_

## 8 Medical History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

- High blood pressure
  - Chest Pains
  - Stroke
  - Rheumatic Fever
  - Shortness of Breath
  - Heart Trouble or Murmur
  - Prosthetic Device
- Need antibiotics before dental treatment \_\_Y, \_\_N
- Lung disease
  - Asthma
  - Allergy to Latex
  - Other allergy or hay fever, explain \_\_\_\_\_
  - Sinus Problem
  - Ulcers or stomach problems
  - Diabetes
  - Hepatitis or liver disease
  - Kidney disease
  - Thyroid trouble
  - Sexually transmitted disease
  - Arthritis
  - Cancer
  - Bruise easily, prolonged bleeding
  - Glaucoma
  - Epilepsy
  - Psychiatric therapy
  - Exposed to HIV
  - HIV or AIDS
  - Possibly pregnant
  - Take birth control pills
  - Joint disease
  - Other, explain \_\_\_\_\_
- None of the above**

## 7 Current Medications

**Child's Physician** \_\_\_\_\_  
Phone \_\_\_\_\_

Please list all current medications and the medical conditions for its use \_\_\_\_\_

9 I understand that the information that I have given is correct, and it is my responsibility to inform this office of any changes in my child's dental and medical status, and medications. I authorize the orthodontist and staff to perform the services for my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

10 I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my orthodontic insurance does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_