UPDIKE ORTHODONTICS

WELCOME

Tell Us About Your Child

Today's Date: Nickname:_____

Child's Name:_____
Last First M

Child's Birthdate:___ ___ ___ Age:_____ ☐ Male ☐ Female

E-mail Address:_____

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home #:_____ SS#:_____

Child's Home Address:_____

_____
City State Zip

General Information

Who is accompanying the child today?
Name:_____ Relation:_____

Do you have a legal custody of this child? ☐Yes ☐No

Whom may we thank for referring you?_____

Other siblings:_____

General Dentist:_____ Last Visit Date:_____

Dentist's Phone #:_____

Relative or Friend not living with you:
Name:_____ Phone:_____

Address:_____

_____
City State Zip

Parent's Information

Who is responsible for account? _____
Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Father ☐ Step Father ☐ Guardian ☐

Name:_____ Birthdate:

Address (If different than child)

_____

_____
City State Zip

SS#:_____ DL#:_____

Work #:_____ Ext:_____ Home #:_____

E-mail_____ Cell/Other #:_____

Employer::_____ Occupation:_____

Employer's Address:_____

_____
City State Zip

Mother ☐ Step Mother ☐ Guardian ☐

Name:_____ Birthdate: ___/___/___

Address (If different than child)

_____

_____
City State Zip

SS#:_____ DL#:_____

Work #:_____ Ext:_____ Home #:_____

E-mail_____ Cell/Other #:_____

Employer::_____ Occupation:_____

Employer's Address:_____

_____
City State Zip

If you have Orthodontic Insurance Coverage for the child please fill it out

Insurance Co Name:_____
Insurance Address:_____

_____
City State Zip

Insurance Phone: _____

Group #(Plan,Local or Policy#)_____

Insurance Co Name:_____
Insurance Address:_____

_____
City State Zip

Insurance Phone:_____

Group # (Plan,Local or Policy#)_____

AUTHORIZATION

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for a treatment fees and may at the discretion of this office, use the services of one or more credit reporting services. 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 insurances does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I Assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature in all my insurance submissions, whether manual or electronic.

_____
Signature **Date**

Dental and Medical History

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

_____

_____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Does your child require antibiotics before dental treatment? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint? (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss hi/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Has the puberty begun? ☐ Yes ☐ No

Has menstruation begun? ☐ Yes ☐ No

Please describe the child's current physical health?

☐Good ☐Fair ☐Poor

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

Y N Latex Y N Nickel/Metals Y N Plastic

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding/Hemophilia	Y N Herpes,Fever Blisters
Y N AIDS	Y N High Blood Pressure
Y N Alcohol/Drug Abuse	Y N HIV
Y N Anemia	Y N Hospitalized
Y N Arthritis	Y N Kidney Problems
Y N Artificial Bones/Joints/Valves	Y N Liver Disease
Y N Asthma	Y N Low Blood Pressure
Y N Blood Transfusion	Y N Lupus
Y N Cancer / Chemotherapy	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay fever	Y N Thyroid Problems
Y N Heart Attack	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Has the child ever taken any diet pills such as Phen-Fen? Y N

Also known as Redux or Pondimin,, if so when?_____

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐

Please discuss any serious medical problems the child has had:

_____

_____

Does/did the child have any of the following habits?

Y N Breast Fed	Y N Nursing Bottle Habits
Y N Clenching/Grinding Teeth	Y N Speech Problems
Y N Lip Sucking/Biting	Y N Thumb Finger Sucking
Y N Mouth Breather	Y N Tongue Thrust
Y N Nail Biting	Y N Used Pacifier

List any musical instruments played:_____

_____

Our office HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 that 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/orthodontic services my child may need.

_____

Signature of Parent or Guardian **Date**

OFFICE USE ONLY

I have verbally reviewed the medical/dental information with the parent/guardian & named herein._____

Signature Dentist Date

Doctor's Comments:

_____

_____

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since your last visit? ☐ Yes ☐ No _____

If yes, please explain:_____ Patient Signature Date

_____

Dentist Signature Date