Welcome To Dr. Mitchell's Orthodontic Office

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Date: ___/___/___

1

Tell Us About Your Child

__ **Male** __ **Female**

Child's Name: ____
Last First MI

Nickname: ___________________

Child's Birthdate: ____/____/____ Child's Age: ______

School: ____

Hobbies/Sports: ____

Child's Home #: ___________________________

Child's Home Address:______________________________________

____
City State Zip

E-Mail Address: ____

2

Who Is Accompanying Your Child Today?

Name: ____

Who does child reside with? ___ Mom ___ Dad ___ Both ___ Other _______________

Parent's Marital Status: __ Single ___ Widowed ___ Married ___ Divorced ___ Separated

Who may we thank for referring you: ______________________________

General Dentist: ____

Address & Phone #: ____

3 ___ **Mother's Information:** ___ Step Mother ___ Guardian

Name: ________________________________ Birth Date: ___/___/___

Home #: _________________________ Cell #: ______________________

E-Mail Address: ____

Mother's Address Same As Child's? ___ Yes ___ No

Other Address: ____

Employer: ____________________________ Job Title:____________________

SS#: ______________________________

___ **Father's Information** ___ Step Father ___ Guardian

Name: ________________________________ Birth Date: ___/___/___

Home #: _________________________ Cell #: ______________________

E-Mail Address: ____

Father's Address Same As Child's? ___ Yes ___ No

Other Address: ____

Employer: ____________________________ Job Title: ____________________

SS #: ______________________________

4 Person Responsible For Account

Name: ____ Relation: ___________________________

Billing Address: ____

____
City State Zip

Home Address if different: ____

____
City State Zip

Home/ Cell #: __________________________________ DL #: ______________________________

Employer: ____________________________________ Wk #:______________________________

SS#: ____

Neighbor or Relative Not living With You

Name: ____________________________________ Phone: _______________________________

Address: ____

____
City State Zip

5 Primary Insurance

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: ____

Insurance Co. Address: ____

Insurance Co. Phone #: ___________________________ Group/ Policy #: _________________

Policy Owner's Name: ____ Relation to Patient: ____________

Policy Owner's Birth Date: ___/___/___ ID #: _______________________________

Policy Owner's Employer: ____

Secondary Insurance

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: ____

Insurance Co. Address: ____

Insurance Co. Phone #: ___________________________ Group/ Policy #: _________________

Policy Owner's Name: ____ Relation to Patient: ____________

Policy Owner's Birth Date: ___/___/___ ID #: _______________________________

Policy Owner's Employer: ____

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

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 (TMD/ TMJ)? ___ 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

Has you child ever taken Phen-Fen? ___ Yes ___ No
(Also known as Redux or Pondium.) If yes, when? __________________

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: __________________________________

____

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

(Please circle Yes or No)

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies to any Drugs
Y N Allergic to Latex / Metals
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defects
Y N Convulsions
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV / AIDS
Y N Kidney Problems Liver Problems
Y N Lupus
Y N Rheumatic Fever / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had: ___________________________________

____

____

8 **Does / Did your child have any of the following habits?**

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

9 I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 the necessary dental services my child may need.

____

Signature of parent or guardian Date

****

I have read and made any changes since my last appointment.

____

Signature of parent or guardian Date

****

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

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