BATES ORTHODONTICS

Welcome to our office. Please fill out both sides of this form.

Tell Us About Your Child:

Today's Date: ____/____/________ ☐ Male ☐ Female

Child's Name: ______________________________
Last First MI

Preferred Name: ______________________________

Child's Birthday: ____/____/________ Age: __________

Preferred Phone Number: (____) ______________________

Child's Home Address: ______________________________

City State Zip Code

School: ______________________________ Grade: __________

Hobbies/ Interests: ______________________________

Siblings w/ Age: ______________________________

Who is accompanying your child today?:

Name: ____________________ Relationship: ____________________

Whom may we thank for you referring you?

____

Parent/Legal Guardian Information:

Parent's Marital Status: ☐ Single ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

☐ **Mother's Information** ☐ Stepmother ☐ Guardian

Name: ______________________________

Birthdate: ____/____/________ Employer: ____________________

Address: ______________________________

City State Zip Code

Phone #: ____________________ Email: ____________________

☐ **Father's Information** ☐ Stepfather ☐ Guardian

Name: ______________________________

Birthdate: ____/____/________ Employer: ____________________

Address: ______________________________

City State Zip Code

Phone #: ____________________ Email: ____________________

Person Responsible for Account:

Name: ____________________ Relation: ____________________

Billing Address: ______________________________

City State Zip Code

Hm #: (____) ____________________ Cell #: (____) ____________________

Email: ______________________________

Preferred method to contact: ______________________________

Employer: ______________________________

Driver's License #: ____________________ State: __________

Insurance Information:

Primary

Orthodontic Coverage?: ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co Phone #: ______________________________

Policy/Subscriber ID: ______________________________

Policy Holder's Name: ______________________________

Relationship to Patient: ______________________________

Policy Holder's Birthdate: ____/____/________

Policy Holder's SS #: ______________________________

Policy Holder's Employer: ______________________________

Secondary

Orthodontic Coverage?: ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co Phone #: ______________________________

Policy/Subscriber ID: ______________________________

Policy Holder's Name: ______________________________

Relationship to Patient: ______________________________

Policy Holder's Birthdate: ____/____/________

Policy Holder's SS #: ______________________________

Policy Holder's Employer: ______________________________

Dental History:

General Dentist: ______

Last Visit: ______

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

If Yes, When: ______

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

If So, When: ______

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 (TMJ/TMD)? ☐ Yes ☐ No

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

______

Does your child have any of the following habits?

- ☐ Clenching/Grinding Teeth
- ☐ Lip Sucking/Biting
- ☐ Thumb/Finger Sucking
- ☐ Tongue Thrust
- ☐ Speech Problems
- ☐ Mouth Breathing

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.

______

Signature of parent or guardian Date

I authorize doctor or designated staff to take x-rays deemed appropriate to make a thorough diagnosis of orthodontic needs: ☐ Yes ☐ No

______

Signature of parent or guardian Date

Medical History:

Has your child ever had:

- ☐ Y ☐ No Abnormal Bleeding
- ☐ Y ☐ No ADD/ADHD
- ☐ Y ☐ No Diabetes
- ☐ Y ☐ No Asthma
- ☐ Y ☐ No Bone Disorders
- ☐ Y ☐ No Handicaps/Disabilities
- ☐ Y ☐ No AIDS/HIV
- ☐ Y ☐ No Epilepsy
- ☐ Y ☐ No Kidney Problems
- ☐ Y ☐ No Liver Problems
- ☐ Y ☐ No Hepatitis
- ☐ Y ☐ No Lupus
- ☐ Y ☐ No Heart Condition
- ☐ Y ☐ No Tuberculosis
- ☐ Y ☐ No Sickle Cell Disease
- ☐ Y ☐ No Allergic to Latex/ Metals
- ☐ Y ☐ No Allergies to any Drugs
- ☐ Y ☐ No Food Allergy

If yes to above, please give details: ______

Child's Physician: ______

Is your child under the care of a physician? ☐ Y ☐ No

Please list all medications your child is currently taking:

______

Is your child currently taking a bisphosphonate for osteoporosis? ☐ Y ☐ N

If so, which ones: ______

Is the patient adopted? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

Boys: Has his voice changed? ☐ Y ☐ N

Girls: Has menstruation begun? ☐ Y ☐ N

If yes, month/year: ______

Please list any additional health information we should know: ______

Additional person we may discuss medical and financial information with:

Name: ______ Relation: ______

☐ Medical ☐ Financial