BATES
ORTHODONTICS

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

Tell Us About Your Child:

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

Name: ______________________________________
First MI Last

Preferred Name: ______________________________

Date of Birth: ____/____/____ Age: __________

Preferred Phone Number: ______________________

Child's 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: ___/___/_______ Cell #: ______________________

Email: ______________________________________

Address: ____________________________________

City: ______________ State: _____ Zip Code: __________

Driver's License #: _______________________ State: _______

Social Security Number: ______________________________

Employer: ____

Work Phone: _______________ Responsible Party? Yes / No

Insurance Information:

Is this ☐ Primary ☐ Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: __________________________________

Policy/Subscriber ID: __________________________________

Parent/Legal Guardian Information:

Parent's Marital Status: ☐ Single ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

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

Name: ________________________

Birthdate: ___/___/_______ Cell #: ______________________

Email: ______________________________________

Address: ____________________________________

City: ______________ State: _____ Zip Code: __________

Driver's License #: _______________________ State: _______

Social Security Number: ______________________________

Employer: ____

Work Phone: _______________ Responsible Party? Yes / No

Insurance Information:

Is this ☐ Primary ☐ Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: __________________________________

Policy/Subscriber ID: __________________________________

Additional Responsible Party:

Name: ______________________ Relation: ______________

Address: ____

City: ______________ State: _____ Zip Code: __________

Home #: _________________ Cell #: ____________________

Email: ____

Additional Insurance Information:

Orthodontic Coverage? ☐ Yes ☐ No

Policy Holder's Name:

____

Policy Holder's DOB: ___/___/____ Relation: ______________

Cell #: ______________________

Policy/Subscriber ID: ____________________________

Social Security Number: ______________________________

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