Braces

Tallahassee Orthodontic Care

D. B. Snead, D.M.D.

Tell Us About Your Child

Today's Date: ____________________

Child's Name: ____________________

Nickname: ____________________ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: ____

School: ____________________ Grade: __________

E-Mail Address: ____________________

Child's Home # ______________ Mobile # ______________

Child's Home Address: ____________________

____

CITY STATE ZIP

Who Is Accompanying Your Child Today?

Name: ______________ Relation: ______________

Do you have legal custody of this child? ❒ Yes ❒ No

Whom may we thank for referring you? ______________

Names, ages and birthdates of siblings: ______________

____

General Dentist: ____________________

Last cleaning date: ____________________

Parent's Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Mother's Information ❒ Step Mother ❒ Guardian

Name ______________ Birthdate: ___/___/___

Employer: ____________________

Wk# ______________ Ext. ____ Hm# ______________

How long at current job? _____ Job Title: ______________

SS# ____________________

Father's Information ❒ Step Father ❒ Guardian

Name ______________ Birthdate: ___/___/___

Employer: ____________________

Wk# ______________ Ext. ____ Hm# ______________

How long at current job? _____ Job Title: ______________

SS# ____________________

Person Responsible For Account

Name ______________ Relation: ______________

Billing Address: ____________________

Employer: ____________________

Wk# ______________ Ext. ____ Hm# ______________

SS# ____________________

Who is responsible for making appointments?

Name ____________________

Wk# ______________ Ext. ____ Hm# ______________

Orthodontic Insurance

Primary Orthodontic Insurance

Orthodontic Coverage: ❒ Yes ❒ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Insured's Birthdate: ___/___/___ Insured's SS# ______________

Insured's Employer: ____________________

Secondary Orthodontic Insurance

Orthodontic Coverage: ❒ Yes ❒ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Insured's Birthdate: ___/___/___ Insured's SS# ______________

Insured's Employer: ____________________

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

____

____

____

Have your child ever had or been evaluated for or had orthodontic treatment before? ❒ Yes ❒ No

Has 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 (TMJ / TMD)? ❒ 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 you child currently under the care of a physician? ❒ Yes ❒ No

Has puberty begun? ❒ Yes ❒ No

Has menstruation begun? (Girls) ❒ Yes ❒ No

Please describe you child's current physical health:

❒ Good ❒ Fair ❒ Poor

Please list all drugs that your child is currently taking:

____

Please list all drugs that your child is allergic to: ______________

____

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

Y N	Abnormal Bleeding	Y N	Handicaps / Disabilities
Y N	Allergies to any Drugs	Y N	Hearing Impaired
Y N	Allergic to Latex / Metals	Y N	Heart Murmur
Y N	Allergic to Plastic	Y N	Hemophilia
Y N	Any Hospital Stays	Y N	Hepatitis
Y N	Any Operations	Y N	HIV+ / AIDS
Y N	Asthma	Y N	Kidney / Liver Problems
Y N	Cancer	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Rheumatic / Scarlet Fever
Y N	Convulsions / Epilepsy	Y N	Tuberculosis (TB)
Y N	Diabetes		

Please discuss any medical problems that your child has had:

____

____

Does you child need to be premedicated with antibiotic prescription before dental treatment? ❒ Yes ❒ No

Does your child have any of the following 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		

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

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.

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Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

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

OFFICE USE ONLY **OFFICE USE ONLY** ***OFFICE USE ONLY*** **OFFICE USE ONLY** ***OFFICE USE ONLY***

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: Initials: ________ Date: ________

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