1. Please complete the following questions for the PATIENT (your child)

PATIENT (your child's) First Name: _____ Middle Initials: _____ PATIENT (your child's) Last Name: _____

PATIENT (your child's) Date of Birth: _____ Gender: ○ Female ○ Male ○ Other

Preferred Pronouns: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

What are your child's interests (hobbies, sports, etc.): _____

2. Primary Responsible Party Information:

Resp. First Name: _____ Middle Initials: _____ Resp. Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Other Marital Status: ○ Single ○ Married

Relationship to patient: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

Employer: _____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

3. Secondary Responsible Party Information (optional):

Resp. First Name: _____ Middle Initials: _____ Resp. Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Other Marital Status: ○ Single ○ Married

Relationship to patient: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

Employer:

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

4. How did you learn about our practice or whom may we thank for referring you?

Referral Source
☐ Google ☐ Social Media ☐ Sign or billboard ☐ Insurance Provider List

Friend or family (enter name):

Dentist (enter name):

Other Website

Other

5. What is the patient's primary concern(s)?

6. Has your child had previous orthodontic treatment?

○ Yes ○ No

7. Have you had a consultation with an orthodontist previously?

○ Yes ○ No

If yes, name of orthodontist:

8. Who is your child's primary care physician?

9. General Dentist Information:

Dentist Name:

Dental visit in last 6 months?:
○ Yes ○ No

Any scheduled treatments?

10. Do you have Orthodontic Insurance?

○ Yes ○ No

11. Primary Insurance

Primary Insurance Company

Member ID / Policy #

Group Number

Patient Relationship to Insured
○ Self ○ Spouse ○ Child
○ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Street Address

Insured City

Insured State

Zip Code

12. Primary Insurance Card: Please take a photo of the FRONT of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

13. Primary Insurance Card: Please take a photo of the BACK of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

14. Do you have Secondary Orthodontic Insurance?

○ Yes ○ No

15. Secondary Dental Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Patient Relationship to Insured
○ Self ○ Spouse ○ Child
○ Other

Insured Name | Insured Phone # | Insured Date of Birth

Insured Street Address | Insured City | Insured State | Zip Code

16. Secondary Insurance Card: Please take a photo of the FRONT of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

17. Secondary Insurance Card: Please take a photo of the BACK of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

18. Check if your child has had any of the following (check all that apply). If checked "Yes" please explain.

- ☐ Anemia
- ☐ Blood disorder
- ☐ Bleeding abnormality
- ☐ Tumor or growth
- ☐ Cancer treatment
- ☐ Radiation treatment
- ☐ Diabetes/ Hypoglycemia
- ☐ Endocrine/ Thyroid problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Bone disorder
- ☐ Joint replacement
- ☐ Rheumatoid arthritis
- ☐ Asthma/COPD
- ☐ Epilepsy
- ☐ Convulsions/ Seizures
- ☐ Fainting/ Dizziness
- ☐ Headaches/Migraines
- ☐ GERD/Acid reflux
- ☐ HIV/ AIDS
- ☐ Herpes
- ☐ Hepatitis B or C
- ☐ Attention deficit disorder
- ☐ Nervous disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment
- ☐ Tobacco/ Vape/ Nicotine use
- ☐ Recreational drug use
- ☐ Current pregnancy

Please add details, and approximate age when condition occurred if not current, for any yes answers above:

19. Indicate any history of (check all that apply); if checked "Yes", please explain.

- ☐ Thumb/ Finger sucking
- ☐ Nail biting
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Mouth breathing
- ☐ Tonsils and adenoids removed
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Grinding and/or clenching of teeth
- ☐ Jaw Pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ History of wearing a mouthguard at night
- ☐ Loose teeth or broken fillings
- ☐ Crowns/ Bridges
- ☐ Root canals
- ☐ Bleeding gums
- ☐ History of Periodontal disease
- ☐ History of Periodontal treatment
- ☐ Mouth sores
- ☐ Cold sores
- ☐ Injury to face or teeth
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity
- ☐ Food collection between certain teeth
- ☐ Missing teeth
- ☐ Extra teeth

Other/Details:

20. Has patient reached puberty?

○ Yes ○ No

If yes (adolescent patients), when/age?

_____

21. Please list any food, drug, or contact allergies:

	Allergy
1	

22. List current medications and the correlating diagnosis:

	Medication	Diagnosis
1		

23. Any serious illnesses, hospitalizations, or other health conditions not listed elsewhere on this form? If yes, please describe.

_____

24. What treatment option(s) interest you?

☐ Invisalign ☐ Metal Braces ☐ Clear braces

☐ Retainers only

25. If treatment is recommended, how soon would you like to get started?

☐ ASAP ☐ Within the month ☐ When recommended

☐ Uncertain

Other:

_____

26. What payment option(s) would you like to review?

☐ No-Interest Monthly Payment ☐ Payment in Full w/Special Courtesy ☐ HSA/FSA

27. Is there anything else you would like us to know before your child's visit?:

_____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date