

Date: _____

Child Welcome Information

Patient's Name _____ Nickname _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Date of Birth _____ SSN _____

School _____ Grade _____ Hobbies or special interests? _____

Are there siblings? (names/ages) _____

Whom may we thank for referring you to our office? _____ Dentist _____

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

Dental Status

When was the patient last seen by the dentist? _____

- Yes No Has the patient had previous orthodontic treatment or consultation? When? Why? _____
- Yes No Has any member of the family had orthodontic treatment? _____
- Yes No Has the patient had any trouble associated with dental treatment? _____
- Yes No Has the patient had any teeth extracted? Why? _____
- Yes No Has the patient ever injured or broken any teeth? When and what happened? _____
- Yes No Has the patient ever injured the head or face? When and what happened? _____
- Yes No Does the patient have any missing or extra teeth? _____
- Yes No Does the patient have any problem with eating, chewing, or swallowing? _____
- Yes No Does the patient suck thumb, fingers, tongue, blanket, or pacifier? (circle which) _____
- Yes No Does the patient have any dental or facial pain? _____
- Yes No Does the patient's jaw joint make noises or hurt when opening, closing, or chewing? _____
- Yes No Does the patient habitually grind or clench the teeth together? _____
- Yes No Does the patient normally breathe with the lips parted? _____
- Yes No Is the patient aware of any swellings or growths in the mouth or face? _____
- Yes No Does the patient have negative or resistant feelings about orthodontic treatment? _____
- Yes No Is the patient especially concerned about orthodontic treatment? _____
- Yes No Is the patient dissatisfied with the appearance of the teeth? _____
- Yes No Is the patient especially resistant to: Braces Headgear Retainers
- Yes No Is there any other information we should know? _____

Medical History

Please list any:

Serious illness or condition _____

Allergies or known drug sensitivity _____

Current medical care _____

Current medications _____

Tonsils and Adenoids: Present Removed at age _____

Yes No Does the patient have frequent colds or ear infections?

Has the patient ever been diagnosed or treated for the following (Check all that apply.):

- | | | | | |
|--|--|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS or HIV+ |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Diabetes |

Responsible Party Information

Name _____ Relationship to Patient _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

SSN _____ Date of Birth _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

Spouse's Name _____ Relationship to Patient _____
Last First Middle

SSN _____ Date of Birth _____

Work Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

A B C

Insurance Information

Insured's Name _____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____ Group No. _____ Local No. _____ Employer _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____ Group No. _____ Local No. _____ Employer _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone _____

Signature of Responsible Party

To the best of my knowledge, the information given is correct. Furthermore, I understand that it is my responsibility to inform this office of any changes in this patient's medical status or insurance information. I authorize Dr. Herrmann to perform a complete orthodontic evaluation including digital photos and 3D digital x-rays. I also understand that diagnostic records and name may be used in educational and promotional purposes. I also understand that in order to receive complete information on financial options, credit bureau reports may be obtained.

Signature: _____ Relationship to Patient: _____ Date: _____