

# Welcome to our Office

Date \_\_\_\_\_

CHILD's Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Sec # \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Social Sec # \_\_\_\_\_ Birth Date \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

School Attending \_\_\_\_\_ Grade \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ General Dentist \_\_\_\_\_

## Responsible Party Information

Responsible Party Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Residence \_\_\_\_\_

Mailing Address \_\_\_\_\_

How long at this Address? \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Sec # \_\_\_\_\_ Birth Date \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number Yrs Employed \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ General Dentist \_\_\_\_\_

Spouse's Information \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Social Sec # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number Yrs Employed \_\_\_\_\_

## Orthodontic Insurance Information

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's Social Sec # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage?  Yes  No

If Yes, please continue:

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's Social Sec # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

1st Insured's Employer \_\_\_\_\_ 2nd Insured's Employer \_\_\_\_\_

If in office financing is desired this office may obtain a credit report of the patient or responsible party prior to extending credit for treatment fees, and may at the discretion of the office use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered, and also responsible for paying any co-payment and deductibles that my insurance does not cover.

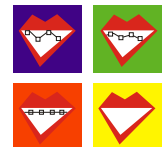
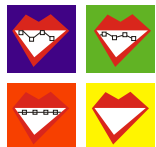
Yes, I would like to qualify for an in office payment plan  No, I do not require an in office payment plan

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please see the reverse side to complete Dental and Medical History information

**Thank you for filling this form out COMPLETELY!**

STEVEN  
**SHORT**  
ORTHODONTICS



## Your child's Medical & Dental history

What are your chief concerns \_\_\_\_\_

Describe what you would like orthodontics to accomplish? \_\_\_\_\_

- Has your child been evaluated or had orthodontic treatment?  Yes  No
- Have there been any injuries to your child's face mouth, teeth or chin?  Yes  No
- Have you or 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
- Is your child currently under the care of a physician  Yes  No

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please describe your child's current physical health  Good  Fair  Poor

Please list any medications/drugs that you are currently taking: \_\_\_\_\_

**Allergies:**

- |   |                     |   |              |
|---|---------------------|---|--------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asprin              | <input type="checkbox"/> Y <input type="checkbox"/> N | Erythomycin  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any Metals/Plastics | <input type="checkbox"/> Y <input type="checkbox"/> N | Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Latex               | <input type="checkbox"/> Y <input type="checkbox"/> N | Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine             |   | Other _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Dental Anesthetics  |   | Other _____  |

Please list any medication/drugs, foods or materials (ie: Latex or Nickel) that your child is allergic to: \_\_\_\_\_

Does your child need to take medication before seeing his/her dentist?  Yes  No

If yes, what? \_\_\_\_\_

**Has your child ever had any of the following:**

- |   |                          |   |                                      |
|---|--------------------------|---|--------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding        | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse / Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Allergies to Any Drugs   | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia                           |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect  | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV+ / AIDS                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis / Liver Disease            |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB)        | <input type="checkbox"/> Y <input type="checkbox"/> N | Allergic to Latex / Metals           |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions / Epilepsy   | <input type="checkbox"/> Y <input type="checkbox"/> N | Allergic to Plastic                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps / Disabilities |   |                                      |

**Has your child ever had any of the following habits:**

- |   |                            |   |                          |
|---|----------------------------|---|--------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Clenching / Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N | Nurse Bottle Habits      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Lip Sucking / Biting       | <input type="checkbox"/> Y <input type="checkbox"/> N | Speech Problems / Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth Breather             | <input type="checkbox"/> Y <input type="checkbox"/> N | Thumb / Finger Sucking   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Nail Biting                | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue Thrust            |

Has your child ever had speech therapy?

If yes, please describe \_\_\_\_\_

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Steven Short's staff to perform necessary dental services that I may need, during diagnosis and treatment as directed by the doctor.



Signature \_\_\_\_\_ Date \_\_\_\_\_