ROCKWALL ORTHODONTICS

YOUTH INFORMATION SHEET

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

Birthdate: _____ /_____ /_____ Age: _____ SS #: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Home #: (_____) _____

Home Address: _____
Apt./Condo #

_____
City State Zip

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relationship: _____

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

How did you hear about us? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Date of last visit: _____

Parent's Marital Status: ❑ Single ❑ Partnered ❑ Divorced
❑ Married ❑ Separated ❑ Widowed

MOTHER'S INFORMATION ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____ /_____ /_____

E-mail Address: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Mobile/Other #: (____) _____

Employed By: _____ How Long: _____

Occupation: _____ Job Title: _____

SS#: _____ DL#: _____

FATHER'S INFORMATION ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____ /_____ /_____

E-mail Address: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Mobile/Other #: (____) _____

Employed By: _____ How Long: _____

Occupation: _____ Job Title: _____

SS#: _____ DL#: _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than parent or guardian)

Name: _____ Relationship: _____

E-mail Address: _____

Billing Address: _____
Apt./Condo #

_____
City State Zip

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

SS#: _____ DL#: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Subscriber ID#: _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Subscriber ID#: _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

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MEDICAL HISTORY

Your child's current physical health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is your child currently under the care of a physician? ❑ Yes ❑ No

If yes, please explain:_____

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

Is your child taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one:_____

_____

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls only) ❑ Yes ❑ No

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

(Please circle Y or N individually)

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N HIV+/Aids
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis

Please list any serious medical condition(s) that your child has ever had:

_____

_____

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

(Please circle Y or N individually)

Y N Aspirin
Y N Any Metals/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: _____

_____

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 any necessary dental services my child may need.

_____
Signature Date

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Have there been any injuries to his/her (please circle): Face Mouth Teeth Chin

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

List any musical instruments played:_____

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS?

(Please circle Y or N individually)

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Snoring
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

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.

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 the office, use the services of one or more credit reporting agencies.

_____
Signature Date

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible(s) that my insurance does not cover.

_____
Signature Date