PATIENT FORM (CHILD)

Wilson & Hendrickson ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible!

PATIENT INFORMATION

Name _____   **Nickname** _____
LAST   FIRST   MIDDLE

Address _____
STREET   CITY   STATE   ZIP

Sex ☐ M ☐ F ☐ OTHER   **E-mail** _____   **Birthdate** _____
MM/DD/YY

Primary Phone _____   **School** _____   **Grade** _____

Sports/Musical Instruments: _____

Siblings _____
PLEASE LIST NAMES AND DATES OF BIRTH

Dentist _____   **Last Visited** _____

How did you hear about our practice? ☐ ADVERTISEMENT ☐ FAMILY/FRIEND ☐ INTERNET ☐ DENTIST ☐ OTHER

Relatives treated by us: _____   **Who referred you to us?** _____

PARENT/GUARDIAN CONTACT INFORMATION   ☐ MOTHER ☐ FATHER ☐ STEP-MOTHER ☐ STEP-FATHER ☐ GUARDIAN

Name _____   **Sex** ☐ M ☐ F ☐ OTHER
LAST   FIRST   MIDDLE

Address _____
(If different than the child's)   STREET   CITY   STATE   ZIP

Marital Status _____   **Birth Date** _____   **E-mail** _____
MM/DD/YY

Home # _____   **Work #** _____   **Cell #** _____

Employer _____   **Occupation** _____

PARENT/GUARDIAN CONTACT INFORMATION   ☐ MOTHER ☐ FATHER ☐ STEP-MOTHER ☐ STEP-FATHER ☐ GUARDIAN

Name _____   **Sex** ☐ M ☐ F ☐ OTHER
LAST   FIRST   MIDDLE

Address _____
(If different than the child's)   STREET   CITY   STATE   ZIP

Marital Status _____   **Birth Date** _____   **E-mail** _____
MM/DD/YY

Home # _____   **Work #** _____   **Cell #** _____

Employer _____   **Occupation** _____

EMERGENCY CONTACT INFORMATION

Name _____

                      LAST   FIRST   MIDDLE

Primary Phone _____ **E-mail** _____

DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ **Policy Owner's Address** _____

Policy Owner's Birth Date _____ **Relationship to Patient** _____

Policy Owner's Employer _____

Insurance Company _____ **Group #** _____ **ID #** _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ **Policy Owner's Address** _____

Policy Owner's Birth Date _____ **Relationship to Patient** _____

Policy Owner's Employer _____

Insurance Company _____ **Group #** _____ **ID #** _____

Insurance Phone _____

MEDICAL AND DENTAL HISTORY

Is your child currently being treated by a physician? ☐ YES ☐ NO **If yes, explain:** _____

Physician _____ **Phone** _____ **Last Visit** _____

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

_____

_____

Has your child ever been evaluated for orthodontic treatment? ☐ YES ☐ NO **If yes, explain:** _____

Has puberty and/or menstruation begun? ☐ YES ☐ NO

Is your child pregnant? ☐ YES ☐ NO **Is your child nursing?** ☐ YES ☐ NO **Is your child taking birth control pills?** ☐ YES ☐ NO

Have your child's tonsils or adenoids been removed? ☐ YES ☐ NO **Has your child ever experienced jaw joint pain (TMJ/TMD)?** ☐ YES ☐ NO

Does your child have speech problems? ☐ YES ☐ NO **If yes, explain:** _____

Do your child's gums bleed? ☐ YES ☐ NO **Does your child like their smile?** ☐ YES ☐ NO

Has your child ever had injury to: ☐ TEETH ☐ MOUTH ☐ CHIN **If yes, explain:** _____

Does your child have any have any missing or extra permanent teeth? ☐ YES ☐ NO

Has your child ever taken any drugs referred to as FenPhen, Redux, or Pondimin? ☐ YES ☐ NO

Does your child smoke or use electronic cigarettes? ☐ YES ☐ NO

Does your child have any of the following habits?

☐ LIP SUCKING/BITING   ☐ PROLONGED BOTTLE/PACIFIER   ☐ MOUTH BREATHER   ☐ THUMB/FINGER SUCKING
☐ NAIL BITING   ☐ CLENCHING/GRINDING TEETH   ☐ TONGUE THRUSTING   ☐ CHEWING/EATING PROBLEM

Is your child allergic to any of the following?

☐ METALS/PLASTICS   ☐ DENTAL ANESTHETICS   ☐ LATEX   ☐ OTHER

List all the drugs your child is currently taking: This would include prescriptions, diet, or over-the-counter medications. Please include the dosage.

_____

_____

Please describe any serious medical condition(s): This would include any allergies, serious illnesses, operations, hospitalizations, or surgeries.

_____

_____

Has your child ever had any of the following?

☐ ADD/ADHD	☐ CORTISONE TREATMENTS	☐ HIGH BLOOD PRESSURE	
☐ ABNORMAL BLEEDING	☐ PERSISTENT COUGH	☐ HIV+/AIDS	☐ SHORTNESS OF BREATH
☐ ANEMIA	☐ COUGHING BLOOD	☐ JAW PAIN	☐ SICKLE CELL DISEASE/TRAITS
☐ ARTIFICIAL BONES/JOINTS/VALVES	☐ DIABETES	☐ KIDNEY PROBLEMS	☐ SINUS PROBLEMS
☐ ASTHMA	☐ DIFFICULTY BREATHING	☐ LIVER DISEASE	☐ SKIN RASH
☐ ARTHRITIS	☐ EPILEPSY/SEIZURES/FAINTING	☐ MISTRAL VALVE PROLAPSE	☐ SWELLING OF FEET OR ANKLES
☐ BACK PROBLEMS	☐ FEVER BLISTERS/HERPES	☐ PSYCHIATRIC PROBLEMS	☐ THYROID PROBLEMS
☐ BLOOD DISEASE	☐ GLAUCOMA	☐ RADIATION TREATMENT	☐ TOBACCO HABIT
☐ BLOOD TRANSFUSION	☐ HEART ATTACK/STROKE	☐ RESPIRATORY DISEASE	☐ TONSILLITIS
☐ CANCER/CHEMOTHERAPY	☐ HEART MURMUR	☐ RHEUMATIC/SCARLET FEVER	☐ TUBERCULOSIS
☐ CHEMICAL DEPENDENCY	☐ HEART SURGERY/PACEMAKER	☐ RHEUMATISM	☐ ULCERS/COLITIS
☐ CIRCULATORY PROBLEMS	☐ HEMOPHILIA	☐ SEVERE/FREQUENT HEADACHES	☐ VENEREAL DISEASE
☐ CONGENITAL HEART DEFECT	☐ HEPATITIS		

SIGNATURE

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 of confidence and it is my responsibility to inform the office of any changes in my child's medical status.

I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by _____   **Date** _____

Health Insurance Portability and Accountability Act

Through the 1996 Health Insurance Portability and Accountability Act, the Department of Health and Human Services established national standards for among other things, the privacy of protected health information. In compliance with these federal regulations, Wilson & Hendrickson Orthodontics may not discuss your medical care with anyone without your express written permission, except in the case of an emergency or as required by law. This does not apply to disclosing information to carry out treatment, payment, or health care operations.

List below the first and last names and relationship to the patient of people with whom you give Wilson & Hendrickson Orthodontics permission to discuss your case (i.e. medication refills, test results, appointment scheduling, billing information, medical history, etc.)

Parents and guardians, be sure to list yourself as well as any other family members or guardians you grant permission.

Name
_____
LAST   FIRST   RELATIONSHIP

Name
_____
LAST   FIRST   RELATIONSHIP

Name
_____
LAST   FIRST   RELATIONSHIP

Name
_____
LAST   FIRST   RELATIONSHIP

Name
_____
LAST   FIRST   RELATIONSHIP

Name
_____
LAST   FIRST   RELATIONSHIP