

WELCOME

To Schouten Orthodontics



Tell Us About Your Child

Today's Date: ____ / ____ / ____ ☐ Male ☐ Female
 Child's Name: _____
 Nickname: _____
 Child's Birthdate: ____ / ____ / ____ Child's Age: ____
 School: _____ Grade: ____
 Hobbies/Sports: _____
 Child's Home #: (____) _____
 Child's Home Address: _____

 E-mail Address: _____



Who is Accompanying Your Child Today?

Name: _____ Relation: _____
 Do you have legal custody of this child: ☐ Yes ☐ No
 Whom may we Thank for referring you? _____
 List brothers/sister with age: _____

 General Dentist: _____
 Last Visit Date: _____
 Parent's Marital Status: ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated



Parent's Information:

☐ Mother ☐ Step Mother ☐ Guardian
 Name: _____ Birthdate: ____ / ____ / ____
 Work #: (____) _____ Ext: ____ Hm #: _____
 Employer: _____
 How long at current job: _____ Job Title: _____
 SSN#: _____ DL #: _____

☐ Father ☐ Step Father ☐ Guardian
 Name: _____ Birthdate: ____ / ____ / ____
 Work #: (____) _____ Ext: ____ Hm #: _____
 Employer: _____
 How long at current job: _____ Job Title: _____
 SSN#: _____ DL #: _____



Person Responsible for Account if other than parents

Name: _____ Relation: _____
 Billing Address: _____

 Previous Address: _____

 Hm #: (____) _____ DL#: _____
 Employer: _____
 Wk#: (____) _____ Ext: _____ SS#: _____



Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____
 Address: _____



Insurance

Primary Insurance

Dental Coverage ☐ Yes ☐ No Ortho Coverage ☐ Yes ☐ No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co Phone: (____) _____
 Group # (Plan, Local, or Policy #): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____ / ____ / ____
 ID# _____

Secondary Insurance

Dental Coverage ☐ Yes ☐ No Ortho Coverage ☐ Yes ☐ No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co Phone: (____) _____
 Group # (Plan, Local, or Policy #): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____ / ____ / ____
 ID# _____



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

Has your child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Y ☐ N

Has your child been informed of any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Y ☐ N

Does your child brush his/her teeth daily? ☐ Y ☐ N

Floss his/her teeth daily? ☐ Y ☐ N

Is your child currently under the care of a physician? _____

Child's physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Has puberty begun? ☐ Y ☐ N

Has menstruation begun? (Girls) ☐ Y ☐ N

Has your child ever taken Phen-Fen? (Also known as Redux or Pondimin?) If yes, when? _____

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs/things that your child is allergic to : _____



Has your child ever had any of the following medical problems?

| | |
|--------------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Diabetes |
| Y N ADD /ADHD | Y N Handicaps/Disabilities |
| Y N Allergies to any drugs | Y N Hearing Impairment |
| Y N Allergic to Latex/Metals | Y N Heart Murmur |
| Y N Allergic to Plastic | Y N Hemophilia |
| Y N Any Hospital Stays | Y N Hepatitis |
| Y N Any Operations | Y N HIV+/AIDS |
| Y N Artificial Bones/ Joints/ Valves | Y N Kidney Problems |
| Y N Asthma | Y N Liver Problems |
| Y N Cancer | Y N Lupus |
| Y N Congenital Heart Defect | Y N Rheumatic/Scarlet Fever |
| Y N Convulsions/Epilepsy | Y N Sick Cell Disease/ Traits |
| | Y N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:



Does / did your child have any of the following habits?

| | |
|--------------------------------|---------------------------|
| Y N Clenching / Grinding Teeth | Y N Bottle Fed |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb/ Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |



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.

My method of payment will be _____

Signature of parent or guardian

Date

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

Signature of parent or guardian

Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments:

Initials: _____ **Date:** _____

