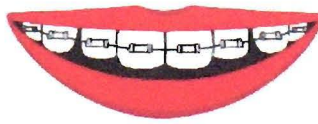


Child's Form



MULLINS ORTHODONTICS

Please fill out this form completely on front and back

TELL US ABOUT YOUR CHILD

GENERAL INFORMATION

Child's Name: _____
 Last First Mi
 Child's Birthdate: ____/____/____ Age: Male Female
 Child's Home #: () _____
 Child's Home Address: _____
 School: _____ Grade: _____
 Hobbies/sports: _____

Who is accompanying the child today?
 Name: _____ Relation: _____
 Do you have legal custody of this child? Yes No
 Other siblings/ages: _____
 General Dentist: _____
 Location: _____
 Dentist's #: () _____

PARENT'S INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT *Please Specify:* _____

FATHER Step Father Guardian

MOTHER Step Mother Guardian

Name: _____
 Last First Mi

Name: _____
 Last First Mi

Address: (if different from Child's) Contact #: () _____

Address: (if different from Child's) Contact #: () _____

Email: _____

Email: _____

SS #: _____ Date of Birth: ____/____/____

SS #: _____ Date of Birth: ____/____/____

Employer: _____

Employer: _____

Employer Address: _____

Employer Address: _____

Parent's Marital Status: Single Married Divorced Separated

Partnered Widow/Widowed

If you have Orthodontic Insurance Coverage for this Child, please fill out below

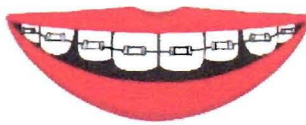
Insurance Co. Name: _____
 Name of Insured: _____
 Phone#: () _____
 ID #: _____

SECONDARY INSURANCE (if any): _____
 Name of Insured: _____
 Phone#: () _____
 ID #: _____

Authorization ~ 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. If this office accepts insurance, 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian _____

Date _____



PATIENT & MEDICAL HISTORY

What main concerns you would like orthodontics to accomplish?

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

Any previous injuries to face, mouth, teeth or chin? Yes No

Child require antibiotics before dental treatment? Yes No

Have adenoids or tonsils been removed? Yes No

Does child have missing/extra permanent teeth? Yes No

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

Does child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of last Visit: _____

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

Has puberty begun? Yes No

Has menstruation begun? Yes No

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

Please list all drugs child is currently taking: _____

Aside from items listed below, list all drugs/things your child is allergic to: _____

Latex Nickel/Metals Plastic

Has the child experienced the following medical problems?

- Y N Abnormal Bleeding Y N Hearing Impairment
Y N ADD/DHD Y N Heart Murmur
Y N AIDS/HIV+ Y N Hemophilia
Y N Any Hospital Stays/Operations Y N Hepatitis
Y N Artificial Bones/Joints/Valves Y N Kidney Problems
Y N Asthma Y N Liver Problems
Y N Cancer Y N Mitral Valve Prolapse
Y N Congenital Heart Defect Y N Prosthetics
Y N Convulsions Y N Rheumatic Fever
Y N Diabetes Y N Scarlet Fever
Y N Epilepsy Y N Sickle Cell Disease/Traits
Y N Handicaps/Disabilities Y N Tuberculosis (TB)

Has the child ever taken ay diet pills such as Phen-Fen? Yes No (Also known as Redux or Pondimin) If so, when? _____

Are child's immunizations current? Yes No

Anything you would like to discuss with Doctor in private? Yes No

Please discuss any serious medical problems the child has had: _____

Does/did the child experience any of the following?

- Y N Breast Fed Y N Nursing Bottle Habits
Y N Clenching/Grinding Teeth Y N Speech Problems
Y N Lip Sucking/Biting Y N Thumb/Finger Sucking
Y N Mouth Breather Y N Tongue Thrust
Y N Nail Biting Y N Used Pacifier

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian Date

~ OFFICE USE ONLY ~

I have verbally reviewed the medical/dental information above with the parent/guardian & patient herein.

Signature of Dentist Date

Dentist's Comments: