Child's Form

MULLINS ORTHODONTICS

Please fill out this form completely on front and back

TELL US ABOUT YOUR CHILD

Child's Name: _____

Last First Mi

Child's Birthdate: _____/_____/_____ Age: ☐ Male ☐ Female

Child's Home #: ( ) _____

Child's Home Address: _____

_____

School:_____ Grade:_____

Hobbies/sports:

GENERAL INFORMATION

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

Name: _____

Last First Mi

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

_____

_____

Email:_____

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

Employer:_____

Employer Address:_____

_____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

☐ **MOTHER** ☐ Step Mother ☐ Guardian

Name: _____

Last First Mi

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

_____

_____

Email:_____

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

Employer:_____

Employer Address:_____

_____

☐ Partnered ☐ Widow/Widowed

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

Insurance Co. Name:_____
Insurance Address:_____
Phone#:_____ID :_____
Group # (Plan, Local, Policy)_____

Insurance Co. Name:_____
Insurance Address:_____
Phone#:_____ID :_____
Group # (Plan, Local, Policy)_____

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

MULLINS ORTHODONTICS

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:

_____

_____

Y N Latex Y N Nickel/Metals Y N Plastic

Has the child experienced the following medical problems?

Y N Abnormal Bleeding
Y N ADD/DHD
Y N AIDS/HIV+
Y N Any Hospital Stays/Operations
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Kidney Problems
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sickle Cell Disease/Traits
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 Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
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: