Welcome to Southwest Orthodontic Associates

Today's Date: _____

Child's Name: _____

Nickname: _____ ❑ Male ❑ Female ❑ Prefer Not to Say

Child's Age: _____ Child's Birth Date: _____

Special Interests: _____

School: _____ Grade: _____

Child's Home Address: _____
Street

_____
City State Zip

Who Is Accompanying Your Child Today?

Name: _____ Relationship: _____

Whom may we thank for referring you? _____

Names of other family members seen by us: _____

_____

Names and ages of other siblings living at home? _____

_____

_____

DENTAL HISTORY

Child's Dentist _____

Date of Last Visit _____

What concerns you most about your child's teeth? _____

Is patient a mouth breather? Yes No

Have there been any injuries to face, mouth, or teeth? Yes No

Any type of thumb or finger sucking habit? Yes No

Do teeth or jaws ever feel uncomfortable first thing in the morning? Yes No

Experience jaw clicking or popping? Yes No

Aware of any clenching or grinding during the day? Yes No

Experience "tension" headaches? Yes No

Has patient completed any speech or tongue therapy? **Yes No**

Is patient self-conscious or sensitive about his/her teeth? Yes No

What is child's attitude toward receiving orthodontic treatment? _____

Are you aware that some appointments will be during school hours? Yes No

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Height of Parents *(Helps us determine child's growth pattern.)* **Mom** _____ **Dad** _____

Does the patient have any allergies? Yes No If yes, list them _____

History of a major illness? _____

Has patient seen an ENT? Yes No **Tonsils / Adenoids removed? Yes No**

Has patient had any other surgeries? Yes No If yes, list them _____

Ever been in a serious accident? Yes No If yes, list them _____

History of sleep apnea in the family? Yes No **If yes, relationship to patient?** _____

Has the child entered puberty? Yes No

***Female Patients Only:* Are you pregnant? Yes No**

Does your child have any specific learning and /or communication needs? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding / Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

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PARENTS INFORMATION

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

Circle One: Mother Stepmother Guardian Cell Phone: _____ Work Phone: _____

Name: _____ SS #: _____ Email: _____

Address: _____ Apt.# _____ State _____ Zip _____

Employer: _____ Length of Employment: _____

Circle One: Father Stepfather Guardian Cell Phone: _____ Work Phone: _____

Name: _____ SS #: _____ Email: _____

Address: _____ Apt.# _____ State _____ Zip _____

Employer: _____ Length of Employment: _____

DENTAL INSURANCE

PRIMARY

Do you have orthodontic coverage? **Yes No**

Insured's Name: _____ Insured's Social Security #: _____

Insured's Employer: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insurance Company: _____ Payor ID #: _____

Insurance Company Address: _____ Phone: _____

Do you have dual coverage? Yes _____ No _____ If yes, complete secondary section below.

SECONDARY

Insured's Name: _____ Insured's Social Security #: _____

Insured's Employer: _____

Insured's Birthdate: _____ Payor ID #: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Company Address: _____ Phone: _____

Insured Relationship to Patient: _____

I understand that Southwest Orthodontics is not accepting certain insurances for example state issued. I have been informed I could seek treatment elsewhere that is accepting my insurance, however, I choose to continue treatment at Southwest Orthodontics. By doing so, I understand I waive my insurance benefit and will cash pay for treatment.

Signature of Parent or Guardian: _____ ***Date:*** _____

EMERGENCY CONTACT

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize payment directly to Southwest Orthodontic Association of all orthodontic insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any deductible that my insurance does not cover. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian: _____ ***Date:*** _____