Welcome to Southwest Orthodontic Associates

Tell Us About Your Child

Today's Date: ______________________________

Child's Name: ______________________________
Last First MI

Nickname: ____________________ Male Female

Child's Home Phone Number: ( ) ________________

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: ________________

Do you have legal custody of this child? Yes No

Is this child in a foster home? Yes No

Whom may we thank for referring you? ______________________________

Names of other family members seen by us: ______________________________

____

Name and ages of other siblings living at home? ______________________________

____

____

DENTAL HISTORY

Child's Dentist: ______________________________ Date of Last Visit: ______________________________

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

How frequently does the child brush his/her teeth? __________

How frequently does the child floss? __________

Has the child seen an orthodontist before? Yes No

What were you told concerning the child's orthodontic problem? ______________________________

What did you like most about any orthodontist you have seen? ______________________________

Does / Did the child have any of the following habits?

Y	N	Chewing on Objects	Y	N	Mouth Breathing	Y	N	Speech Problems
Y	N	Clenching / Grinding Teeth	Y	N	Nail Biting	Y	N	Thumb / Finger Sucking
Y	N	Lip Sucking / Biting	Y	N	Popping and Clicking in Jaw	Y	N	Tongue / Cheek Biting

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MEDICAL HISTORY

Child's physician: ______________________________

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

Please explain: ______________________________

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

Please list all medications and their respective conditions for which the child is being treated: ______________________________

Is the child allergic to latex? Yes No Please list all other allergies: ______________________________

Does the child receive antibiotic pre-medication before dental procedures? Yes No

Does the child use any tobacco products? Yes No

Has the child had/experienced any of the following:

Y	N	Abnormal Bleeding	Y	N	Congenital Heart Defect	Y	N	High Blood Pressure
Y	N	Abnormal Blood Pressure	Y	N	Convulsions	Y	N	Low Blood Pressure
Y	N	Aids/HIV +	Y	N	Diabetes	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Hearing Impairment	Y	N	Tuberculosis
Y	N	Cancer	Y	N	Hepatitis	Y	N	Severe Visual Impairment

Please discuss any other pertinent health problems the child experiences/ed: ______________________________

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South Side Press F12014-C

PARENTS INFORMATION

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

Circle One: Mother Stepmother Guardian Home Phone #: (___)__________ Work Phone #: (_____)__________

Cell Phone #: (___)__________ Email Address: __________

Name: ______________________________ SS#: __________

Address: ____
Street Apartment No. City State Zip

Employer: ______________________________ Length of Employment: __________

Circle One: Father Stepfather Guardian Home Phone #: (_____)__________ Work Phone Number: (_____)__________

Cell Phone #: (_____)__________ Email Address: __________

Name: ______________________________ SS#: __________

Address: ____
Street Apartment No. City State Zip

Employer: ______________________________ Length of Employment: __________

PERSON RESPONSIBLE FOR ACCOUNT

Name: __________________ Relationship: __________ SS#: __________

Billing Address: ____
Street Apartment No. City State Zip

Work Phone #: (_____)__________ Home Phone #: (_____)__________ Employer: __________

May we request a credit report for the responsible party? Yes No

INSURANCE INFORMATION

Do you have orthodontic coverage? Yes No If "yes" - Insurance Company Name: __________

Phone #: (_____)__________ Group # (Plan or Policy #): __________

Company Address: ____
PO Box/ Street City State Zip

Policy Owner's Name: ______________________ Relationship to Patient: __________

Policy Owner's Birth Date: ___/___/___ Social Security #: __________ Policy Owner's Employer: __________

Do you have a Flex Pay / Cafeteria Plan? Yes No Do you have secondary orthodontic coverage? Yes No
(If yes, please inform the receptionist.)

Medical Assistance (Title XIX) Yes No
Patient Identification Number: __________ County: __________

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.

______________________________ __________
Signature of Parent or Guardian Date

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

______________________________ __________
Signature of Doctor Date