WELCOME
TO JOHNSON ORTHODONTICS

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthday: _____/_____/____ Child's Age: _____

Nickname: _____ Male ____ Female ____

School: _____ Grade: _____

Home Phone:_____ Hobbies:_____

Home Address: _____

_____
City State Zip

Email Address: _____

Who is Accompanying the Child Today?

Name: _____ Relation: _____

Whom may we thank for referring you? _____

Other siblings and ages: _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status:___Single___Married___Remarried
___Widowed ___ Divorced ___ Separated

2 Parent Information

____ Mother ____ Stepmother ____ Guardian

Name: _____

Birthday: ___/___/___ SS# _____

Employer: _____

Occupation: _____

Work # _____ Home # _____

Cell # _____

____ Father _____ Stepfather _____ Guardian

Name: _____

Birthday: ___/___/___ SS# _____

Employer: _____

Occupation: _____

Work # _____ Home # _____

Cell # _____

3 Person Responsible For Account

Name: _____

Billing Address: _____

_____

How long at this address: _____ Phone #: _____

Previous Address: _____

_____

Employer: _____ Work #:_____

Relationship: _____ SS#: _____

Who Is Responsible for Making Appointments?

Name: _____

Work # _____ Home # _____

Cell # _____

4 Orthodontic Insurance Coverage

Ins. Co. Name: _____

Ins. Co. Address: _____

_____
City State Zip

Ins. Phone #: _____

Policy Owner's Name: _____

Relationship: _____

Birthday ___/___/___ SS# _____

Policy Owner's Employer: _____

Employer's Address: _____

! 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.

5 Dental History

What is the primary reason for today's visit?

_____
_____
_____

Has the child experienced problems with previous dental work? ___ yes ___ no
Is the child's water fluoridated? ___ yes ___ no
Is the child taking fluoridated supplements? ___ yes ___ no

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)? ___ yes ___ no

Does the child brush his/her teeth daily? ___ yes ___ no
Floss his/her teeth daily? ___ yes ___ no

Child's Physician: _____

Phone #: (___)_____ Last visit: _____

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

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

Please list all drugs that the child is currently taking:

_____
_____
_____

Please list all drugs that cause the child allergic reactions:

_____
_____
_____

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

6 Medical History

Has the child experienced the following medical problems?

Y N Abnormal Bleeding
Y N AIDS/ HIV+
Y N Anemia
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defects
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but neg.
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Allergies
Y N Kidney
Y N Liver Problems
Y N Low Blood Pressure
Y N Measles
Y N Mononucleosis
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)
Y N Heart Murmur

Would you like to discuss anything with the Doctor in private?

_____ yes _____ no

Please discuss any serious medical problems the child experiences/ed: _____
_____

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

Y N Lip Sucking/Biting
Y N Nail Biting
Y N Chewing on Objects
Y N Mouth Breather
Y N Clenching/Grinding Teeth
Y N Used Pacifier
Y N Tongue Thrust
Y N Thumb/Finger Sucking
Y N Tongue/Cheek Biting
Y N Speech Problems
Y N Nursing Bottle Habits

I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of Parent or Guardian **Date**

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____
Signature **Date**

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.

_____
Signature **Date**

Office Use Only

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein. Initials: ___
Doctor's comments:

_____
_____
_____
_____

Medical History Update

Date _____ Signature _____
Comments: _____
_____
Date _____ Signature _____
Comments: _____
_____