Abay Orthodontics

CONFIDENTIAL

ABOUT YOUR CHILD

Today's Date: _____ / _____ / _____

Child's Name: _____
(Last) (First) (M.I.)

Nickname: _____ Male ☐ Female ☐

Child's SSN#: _____ / _____ / _____

Child's Birth Date: _____ / _____ / _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home Phone: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

List Brothers/Sister with ages: _____

_____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relation: _____

Do you have legal Custody of this Child? Yes ☐ No ☐

Who may we thank for referring you? _____

General Dentist: _____

Last Visit Date: _____ / _____ / _____

Parent's Martial Status: Single ☐ Married ☐
Separated ☐ Widowed ☐ Divorced ☐

Mother's Info: Mother ☐ Step Mother ☐ Guardian ☐

Name: _____ Birthday: _____

Home Phone: _____

Work Phone: _____ Ext: _____

Employer: _____ Job Title: _____

How long at the current Job: _____

DL#: _____ SSN#: _____ / _____ / _____

Father's Info: Father ☐ Step Father ☐ Guardian ☐

Name: _____ Birthday: _____

Home Phone: _____

Work Phone: _____ Ext: _____

Employer: _____ Job Title: _____

How long at the current Job: _____

DL#: _____ SSN#: _____ / _____ / _____

The parent or guardian who accompanies the child is responsible for payment.

ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group#: _____

SSN#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthday: _____

Policy Owner's Employer: _____

Secondary

Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group#: _____

SSN#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthday: _____

Policy Owner's Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
(Last) (First) (M.I.)

Home Phone: _____

Work Phone: _____ Ext: _____

Billing Address: _____

_____
(City) (State) (Zip)

Previous Address: _____

_____
(City) (State) (Zip)

Relation: _____ Employer: _____

DL#: _____ SSN#: _____ / _____ / _____

Who is responsible for making appointments?

_____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Abnormal Bleeding	Y	N	Diabetes	Y	N
Allergies to any Drugs	Y	N	Handicaps / Disabilities	Y	N
Allergic to Latex / Metal	Y	N	Hearing Impairment	Y	N
Allergic to Plastic	Y	N	Heart Murmur	Y	N
Any Hospital Stays	Y	N	Hemophilia	Y	N
Any Operations	Y	N	Hepatitis	Y	N
Asthma	Y	N	HIV +/ AIDS	Y	N
Cancer	Y	N	Kidney / Liver Problem	Y	N
Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever	Y	N
Convulsions	Y	N	Tuberculosis (TB)	Y	N

Please discuss any medical problem that your child has had: _____

_____

Child's Physician: _____

Phone: _____ Date of Last Visit: _____

Is child currently under the care of a physician? Y ☐ N ☐

Has Puberty begun? Y ☐ N ☐

For Girls: Has Menstruation begun? Y ☐ N ☐

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

Please list all drugs that your child is currently taking:

_____

_____

Please list all drugs that your child is allergic to:

_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Has your child ever been evaluated or had orthodontic treatment before? Y ☐ N ☐

Has your child ever had injury to: Mouth ☐ Teeth ☐ Chin ☐

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Y ☐ N ☐

List any musical instrument played:

Have adenoids or tonsils been removed? Y ☐ N ☐

Has your child been informed of missing or extra permanent teeth? Y ☐ N ☐

Does your child brush his / her teeth daily ? Y ☐ N ☐

Floss his / her teeth daily? Y ☐ N ☐

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

Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits	Y	N
Lip Sucking / Biting	Y	N	Speech Problem	Y	N
Mouth Breathing	Y	N	Thumb / Finger Sucking	Y	N
Nail Biting	Y	N	Tongue Thrust	Y	N

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

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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 service my child may need during diagnosis and treatment with my informed consent.

_____ / _____

(Signature of parent or guardian) (Date)

I authorize my insurance company to pay Dr. Emeline Abay all insurance benefits otherwise payable to me for service rendered. I authorized the use of this signature on all insurance forms. I authorize Dr. Emeline Abay to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ / _____

(Signature of parent or guardian) (Date)

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials _____ Date: _____

_____

_____

_____