SUNDANCE ORTHODONTICS

Child Orthodontic Record

PATIENT INFORMATION

Last Name _____ First Name _____
Nickname or Preferred Name _____ Age _____ Birth Date ____ /____ /_____ Sex: M [ ] F [ ]
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Has any family member received treatment at our office? Yes [ ] No [ ] if yes, who? _____
Dentist _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Birth Date ____ / ____ /_____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Time at this address _____ Relationship to patient _____ Email _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Current Employer _____ Occupation _____
Spouse's Name _____ Birth Date ____ / ____ /_____ Relationship to patient _____

If a parent (responsible party) is not living with the patient, please complete the following
Last Name _____ First Name _____ Birth Date ____ /____ /_____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

ORTHODONTIC INSURANCE INFORMATION

Insurance Company (Primary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. ____ - ____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

Insurance Company (Secondary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. ____ - ____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

INITIAL EXAM INFORMATION

What is your chief concern in seeking orthodontic care? _____
What is your dentist's main concern regarding the patient's bite? _____
In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes [ ] No [ ]

Our policy is that the adult who requests treatment is responsible for all fees for services rendered.

SIGNATURE ON FILE

By signing below:

- I authorize the use of this form and its information for all my insurance submissions.
- I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.
- I authorize insurance payment directly to this office.
- I authorize the use of a copy of this form which can be used in place of the original.
- I understand where appropriate a credit report may be obtained.
- I understand where appropriate my credit card information may be obtained.

Signature _____ **Date** ____/ ____/ _____

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MEDICAL HISTORY

Name of patient's physician_____ Physician's Phone (____) _____-_____

Please check yes or no for each condition (if yes, please explain)

Allergies
Yes [ ] No [ ] Acrylic
Yes [ ] No [ ] Aspirin
Yes [ ] No [ ] Ibuprofen
Yes [ ] No [ ] **Latex**
Yes [ ] No [ ] Metals
Yes [ ] No [ ] Nickel
Yes [ ] No [ ] Other _____

Yes [ ] No [ ] Arthritis
Yes [ ] No [ ] Asthma
Yes [ ] No [ ] Attention Deficit Disorder

Blood disorders
Yes [ ] No [ ] Anemia
Yes [ ] No [ ] Bruise easily
Yes [ ] No [ ] Excessive bleeding
Yes [ ] No [ ] Other _____

Blood pressure conditions
Yes [ ] No [ ] high
Yes [ ] No [ ] low

Yes [ ] No [ ] AIDS or HIV positive

Yes [ ] No [ ] Cancer
Yes [ ] No [ ] Chemo
Yes [ ] No [ ] Radiation

Cardiovascular conditions
Yes [ ] No [ ] Angina
Yes [ ] No [ ] Heart attack
Yes [ ] No [ ] Heart defect
Yes [ ] No [ ] Heart murmur
Yes [ ] No [ ] Stroke
Yes [ ] No [ ] Other _____

Neurological disorders
Yes [ ] No [ ] Epilepsy
Yes [ ] No [ ] Fainting
Yes [ ] No [ ] Seizures
Yes [ ] No [ ] Other _____

Yes [ ] No [ ] Headaches/migraines
Yes [ ] No [ ] Hepatitis
Yes [ ] No [ ] Kidney disorders

Does your child have any other medical conditions that we should know about?

If yes, please explain:
_____
_____
_____
_____
_____
_____

MEDICATION HISTORY

Yes [ ] No [ ] Does your child take any prescription medication, over the counter medication, nutritional supplements, or herbal medication?

Please list all medications...

Medication	Taken for

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DENTAL HISTORY

Yes [ ] No [ ] Are your child's x-rays and fluoride treatments up to date?
Yes [ ] No [ ] Has your child seen the dentist in the past six months?
Yes [ ] No [ ] Does your child have missing teeth?
Yes [ ] No [ ] Does your child have extra teeth?
Yes [ ] No [ ] Does your child have slowly erupting teeth?
Yes [ ] No [ ] Does your child have un-erupted teeth?
Yes [ ] No [ ] Does your child have thin gum tissue?
Yes [ ] No [ ] Does your child brush and floss regularly?
Yes [ ] No [ ] Has your child ever had any orthodontic treatment completed?
If yes, please explain_____

Is there anything else about your child's dental history that we should know about?_____

Now or in the past has your child had...

Yes [ ] No [ ] ...any history of injured teeth?
Yes [ ] No [ ] ...injury to the head, neck, or jaws?
Yes [ ] No [ ] ...periodontal or "gum tissue" problems?

Jaw joint history
Yes [ ] No [ ] ...history of jaw joint pain?
Yes [ ] No [ ] ...history of jaw joint clicking or locking?
Yes [ ] No [ ] ...history of treatment for TMD or TMJ?

Functional/habit history
Yes [ ] No [ ] ...history of thumb or finger habit?
Until what age?_____
Yes [ ] No [ ] ...history of tongue thrusting?
Yes [ ] No [ ] ...history of abnormal swallowing?

If yes to any above, please explain _____

Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns, please indicate what you would like orthodontics to accomplish for your family:

[ ] Enhance aesthetics and appearance
[ ] Improve function, comfort, and stability
[ ] Enhance overall dental health
[ ] Create facial balance
[ ] Increase self confidence
[ ] Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

Signature _____ **On behalf of** _____ **Date** ____ **/** ____ **/**
(responsible party) (patient)