WELCOME TO

Yamashiro ORTHODONTICS

1 Tell Us About Your Child

Today's Date:_____ ☐ Male ☐Female

Child's Name: _____
Last First MI

Nickname:_____SS#:_____

Child's Birthdate:___/____/____Child's Age:_____

School:_____Grade:_____

Hobbies/Sports:_____

Child's Home#:_____

Child's Home Address:_____

_____

2 Who Is Accompanying Your Child Today?

Name:_____Relation:_____

Do you have legal custody of this child? ☐Yes ☐No

Whom may we Thank for referring you?_____

List brothers/sisters with age:_____

_____

General Dentist:_____

Last Visit Date:_____

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

3 Mother's Information: ☐ Step Mother ☐Guardian

Name:_____Birthdate:___/___/___

Wk#:_____Ext:_____Hm#:_____

Employer:_____

Email: _____Job Title:_____

Would you like Apt reminders? ☐Yes ☐No

Father's Information: ☐Step Father ☐Guardian

Name:_____Birthdate:___/___/___

Wk#:_____Ext:_____Hm#:_____

Employer:_____

Email:_____Job Title:_____

Would you like Apt reminders? ☐Yes ☐No

4 Person Responsible For Account

Name:_____Relation:_____

Billing Address:_____

_____

Email Address for correspondence:_____

_____

Hm#:_____DL#:_____

Employer:_____

Wk#:_____Ext:_____SS#:_____

Who is responsible for making appointments?

Name:_____

Wk#:_____Ext:____Hm#:_____

5 Primary Orthodontic Insurance

Orthodontic coverage? ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group#(Plan, Local, or Policy#):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/___ID#:_____

Policy Owner's Employer:_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group#(Plan, Local, or Policy#):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/___ID#:_____

Policy Owner's Employer:_____

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

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐Yes ☐No

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

List any musical instruments played:_____

Have adenoids or tonsils been removed? ☐Yes ☐No

Has your child been informed of any missing or extra permanent teeth? ☐Yes ☐No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐Yes ☐No

Does your child brush his/her teeth daily? ☐Yes ☐No

Floss his/her teeth daily? ☐Yes ☐No

Child's Physician:_____

Phone#:(_____)_____Date of last visit:_____

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

Has puberty begun? ☐Yes ☐No

Has menstruation begun? (Girls) ☐Yes ☐No

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/things that your child is allergic to:

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

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps/Disabilities
Y	N	Allergic to Latex/Metals	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 Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions/Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

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

Y	N	Clenching/Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip sucking/biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb/Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you.

Name:_____Phone:_____

Address:_____

_____

9 I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of conficence 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 services my child may need.

_____

Signature of parent or guardian Date

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

_____

Signature of parent or guardian 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 may insurance does not cover

_____

Office Use Only 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:_____

_____

_____

_____