ROSENBERG ORTHODONTICS, PC

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PATIENT INFORMATION *for* **CHILD**

Child's Name	Nickname	Age	Date of Birth	Sex
Home Address			Town/Zip code	Home Phone
Mother's name	Address		Social Security #:	Home Phone
Mother's employer	Address		Town/Zip code	Work Phone
Father's name	Address		Social Security #:	Home Phone
Father's employer	Address		Town/Zip code	Work Phone

Mother's Cell and Email: Father's Cell and Email:

Names & ages of brothers & sisters

Child's Dentist Town/Zip code Date of last dental cleaning

How was your child referred to our office? Reason for seeking orthodontic treatment?

Has your child ever seen or been treated by another orthodontist? YES ❑ NO ❑

PATIENT MEDICAL HISTORY

How is your childs general health? _____

Has your child ever had any of the following? *(please check yes or no)*

	YES	NO		YES	NO		YES	NO
Heart abnormality	❑	❑	Any operations?	❑	❑	Kidney/Liver problems	❑	❑
Rheumatic Fever	❑	❑	Diabetes	❑	❑	Cancer	❑	❑
Hepatitis	❑	❑	Cerebral Palsy	❑	❑	Hearing impairment	❑	❑
Ever been hospitalized?	❑	❑	Does patient take medicine?	❑	❑	Visual impairment	❑	❑
Tuberculosis	❑	❑	Allergies to medicine?	❑	❑	Frequent sore throats	❑	❑
Blood transfusions	❑	❑	Allergies to latex?	❑	❑	Earaches	❑	❑
Bleeding/Clotting problems	❑	❑	Tonsils/Adenoids removed	❑	❑	Respiratory problems/Asthma	❑	❑
HIV+/AIDS	❑	❑	Convulsions/Epilepsy	❑	❑	If female: pregnant?	❑	❑

If you answered YES to any of the above questions, please explain:

Any other medical condition we should know about?

→ *Please turn form over and complete other side*

DENTAL HISTORY

(Please check yes or no)

	YES	NO	If you answered YES to any of the questions, please explain:
Has your child ever had a difficult problem associated with previous dental work?	❑	❑	_____
Does your child ever grind or clench his/her teeth?	❑	❑	_____
Is your child's water source fluoridated?	❑	❑	_____
Any injuries to teeth, face or head?	❑	❑	_____
Does your child have TMJ problems, clicking or painful jaw?	❑	❑	_____
Does your child have a history of thumb/finger sucking habits, tongue habits?	❑	❑	_____

Current_____ Past_____ Until age_____

Who brushes your child's teeth? _____

When _____

PAYMENT INFORMATION

(Person responsible for account)

Name			Social Security #
Billing Address		Town	Zip Code
Home Phone	Work Phone	Mother's Cell	Father's Cell

Are you or your spouse employed by the U.S. Military or Reserve Corps? YES ❑ NO ❑

PRIMARY INSURANCE

Name of Policy Holder/Subscriber	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES ❑ NO ❑	Orthodontic Coverage? YES ❑ NO ❑

SECONDARY INSURANCE

Name of Policy Holder/Subscriber	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES ❑ NO ❑	Orthodontic Coverage? YES ❑ NO ❑

I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct and I will notify you of any changes. I authorize the dental staff to perform the necessary dental services I may need. I understand and agree that I am financially responsible for the balance of my account and for any professional services rendered regardless of my insurance. I understand there is no charge for my initial evaluation; however, any orthodontic diagnostic records taken will be charged to my account.

Signature _____ Date _____

Revised: 12/2013