American Association of Orthodontists

Lisa Angelici, D.M.D., Inc.

Practice Limited to Orthodontics

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PLEASE PRINT

1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
LAST FIRST MI

Nickname:_____

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

School:_____ Grade:_____

Child's Home #: (____)_____

Child's Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

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?_____

Other family members seen by us:_____

_____

General Dentist Name:_____

Address:_____

Last Teeth Cleaning Date:_____

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

If parents are separated/divorced, patient lives with:_____

3 Mother's Information: ❑ Mother ❑ Step Mother ❑ Guardian

Name:_____

WK #:(___)_____ Ext:_____ HM#:(___)_____

Employer:_____

Occupation:_____ DL#_____

SS#:_____ Date of Birth:_____

Cell/Other #:(___)_____ Email:_____

Father's Information: ❑ Father ❑ Step Father ❑ Guardian

Name:_____

WK #:(___)_____ Ext:_____ HM#:(___)_____

Employer:_____

Occupation:_____ DL#_____

SS#:_____ Date of Birth:_____

Cell/Other #:(___)_____ Email:_____

4 Person Responsible for Account

Name:_____

WK #:(___)_____ Ext:_____ HM#:_____

Billing Address:_____

Relationship:_____ SS#:_____

Employer:_____ DL#_____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

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

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthday:_____/_____/_____

SS#:_____

Insured's Employer:_____

Employer Address:_____

_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

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

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthday:_____/_____/_____

SS#:_____

Insured's Employer:_____

Employer Address:_____

_____

CONTINUED ON BACK OF FORM

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

If yes please explain _____

Has 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:_____

_____

Is your child allergic to any of the following items?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental Anesthetics	Y N	Any Metal/Plastic
Y N	Codeine	Y N	Erythromycin	Y N	Other

Please list all drugs that your child is allergic to:_____

_____

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

Y N	Allergic to Plastic	Y N	Allergic to Latex/Metals
Y N	Heart Murmur	Y N	Congenital Heart Defect
Y N	Cancer	Y N	Convulsions/Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheumatic Fever	Y N	Hearing Impairment
Y N	HIV+/AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any stays in a hospital
Y N	Asthma	Y N	Kidney/Liver Problems
Y N	Hepatitis	Y N	Handicaps/Disabilities
Y N	Tuberculosis (TB)	Y N	Allergies to any Drugs

Please discuss any medical problems that your child has had:

_____

_____

8 Has your child ever had any of the following habits?

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

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 confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am aware that I am responsible for all costs of orthodontic treatment and may incur collection costs if not paid in full at the time of service.

_____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

This authorization is valid for 12 months from the date above.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Lisa Angelici, D.M.D., Inc.

_____

SIGNED (INSURED PERSON) DATE

This authorization is valid for 12 months from the date above.

9

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 Date

Thank you for filling out this form completely.

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

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 patient named herein. Initials_____ Date_____

Doctor's Comments:

_____

_____

_____

Update HH. Date_____Initials_____ Date_____Initials_____