

Greg Carr DMD, MS
Specialist in Orthodontics

NEW PATIENT INFORMATION – CHILD & TEEN

Please fill out this form as completely as you can. The better we communicate, the better we can care for you.

Date _____
Patient's Name _____ Prefers to be called _____ Sex M F
Address _____ City _____ Zip _____
Age _____ Birth date _____ Patient mainly resides with: Both parents Mother Father Other _____
Do you have legal custody of this child? Yes No Other family members seen by us _____
Who may we thank for referring you? _____
Main orthodontic concern(s) _____

BILLING PARTY INFORMATION

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Cell # _____ Home # _____ Email _____
Marital Status Single Married Divorced Widowed Birth date _____ SSN _____
Employed by _____ How long? _____ Occupation _____
Spouse's Name _____ Birth date _____ SSN _____
Employed by _____ How long? _____ Occupation _____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ Insured's Birth date _____
Insured's SSN/ID# _____ Insured's Employer _____
Insurance Company _____ Group # _____ Effective Date _____
Phone # _____ Do you have orthodontic coverage? Yes No
Secondary Insured's Name _____ Insured's Birth date _____
Insured's SSN/ID# _____ Insured's Employer _____
Insurance Company _____ Group # _____ Effective Date _____
Phone # _____ Do you have orthodontic coverage? Yes No

(CONTINUED ON REVERSE SIDE)
MEDICAL & DENTAL HISTORY

Dentist's Name _____ Month/Year of last check-up _____

Please describe patient's health: Good Fair Poor. Currently under care of a physician? Yes No Reason: _____

Does the patient take any medications? Yes No

Please list all medications taken: _____

Allergy or adverse reaction to any medications? _____

Allergy to latex, metal or any dental/medical products? Yes No _____

Require antibiotic pre-medication for any heart condition when seeing the dentist? Yes No

Ever taken any Bisphosphonate medication (ex: Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)? Yes No

Please check box if the patient has or ever had any of the following:

- | | | |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever/Scarlet fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Adenoids/Tonsils removed | <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Liver Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies/Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions/Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing impairment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Handicaps/Disabilities |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Operations/Stays in Hospital |

Any other disease, condition or problem not listed above? _____

Has there ever been any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Has there ever been any serious/difficult problem associated with dental work? Yes No

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

Have you been informed of any missing or extra permanent teeth? Yes No

Are there any speech problems or difficulties? Yes No

Thumb/Finger sucking Yes No

Tongue Thrusting Yes No

Lip sucking/biting Yes No

Nail biting Yes No

Strong tendency for mouth breathing? Yes No

Have you consulted an orthodontist previously? Yes No

Are there any other family members with similar orthodontic conditions? Father Mother Brother/Sister Other

Authorizations

The information on this questionnaire is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services the patient may need and I have the legal authority to authorize this for the patient.

I authorize my insurance company or companies to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize this office to submit insurance claims on the patient's behalf. I understand that I am financially responsible for any difference between estimated insurance benefits and actual benefits.

Print Name _____

Signature _____

Date _____

OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

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

Initials _____ Date _____ Comments _____

Update: Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____