

PATIENT INFORMATION

Date _____

PLEASE TELL US ABOUT YOUR CHILD

Child's Name: _____
LAST FIRST MI

My child prefers to be called: _____

Male Female

Date of Birth: ____/____/____ Age: _____

Child's Home #: (____) _____

Child's Home Address: _____

CITY STATE ZIP

E-mail Address: _____

CHILD'S DENTIST

Name: _____ Last visit: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

Other referrals: _____

Other siblings & ages: _____

Child's School: _____ Grade: _____

Hobbies/Sports: _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: _____ Marital Status: _____

Address: _____
STREET CITY STATE ZIP OWN RENT

How long at this address: _____ Home #: (____) _____ Work #: (____) _____

Previous address (if less than 3 yrs.): _____
STREET CITY STATE ZIP

SS #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

SS #: _____ Birthdate: _____ Work #: (____) _____

Child's Parents/Legal Guardian's Name: _____

Preferred Contacts: Email: _____ Cell: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No

Insurance Name: _____

Insurance Address: _____

CITY STATE ZIP

Insurance Phone #: (____) _____

Group # (plan or policy #): _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: _____

Insured's Employer: _____

Insured's SS #: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No _____

Insurance Name: _____

Insurance Address: _____

CITY STATE ZIP

Insurance Phone #: (____) _____

Group # (plan or policy #): _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: _____

Insured's Employer: _____

Insured's SS #: _____

Orthodontics Dedicated to Patient Satisfaction & High Ethical Standards

DENTAL HISTORY

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

	YES	NO
Has your child ever been evaluated by an Orthodontist or had Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Has there ever been any severe injuries to the face, mouth, teeth, or chin?	<input type="checkbox"/>	<input type="checkbox"/>
List any musical instruments played: _____		
Have tonsils/adenoids been removed?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been informed of any missing or extra permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had any pain or tenderness in his/her jaw joint (TMJ or TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Child's General Physician: _____		
Phone #: (_____) _____ Last Seen _____		
Is your child currently under the care of a physician for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Explain: _____		
Doctor's Name: _____		
Has puberty begun?	<input type="checkbox"/>	<input type="checkbox"/>
Has menstruation begun? (girls).....	<input type="checkbox"/>	<input type="checkbox"/>
Please describe your child's current general health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Please list all drugs that your child is currently taking: _____		
Please list all drugs to which your child is allergic: _____		

MEDICAL HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex/plastic	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (any type)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Any Operations	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hospital <input type="checkbox"/> In-patient		

Please discuss any medical problems that your child has had: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

	YES	NO		YES	NO		YES	NO
Thumb/Finger Sucking.....	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breather	<input type="checkbox"/>	<input type="checkbox"/>	Nail Biting	<input type="checkbox"/>	<input type="checkbox"/>
Lip Sucking/Biting	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tongue Thrust	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/Grinding Teeth	<input type="checkbox"/>	<input type="checkbox"/>						

I understand that the information I have given above is correct to the best of my knowledge, that where appropriate credit bureau reports will be obtained, and that it will be held in strict confidence. It is my responsibility to inform Dr. Sadler of any changes in my child's medical and dental status. I hereby authorize release of information for any proposed treatment to my/our insurance company and for insurance payment of said treatment to be paid directly to Sadler Orthodontics. I further authorize release of orthodontic records to other healthcare providers involved in my dental/orthodontic care and the use of these records by Dr. Sadler for teaching purpose and or scientific publication. In addition, I acknowledge that I have received a notice of privacy practices from Sadler Orthodontics.

Signature of Parent or Guardian

Date

Signature of Insured Person

Date