

Long Orthodontic Associates, LLC  
Child Patient Information

**Tell Us About Your Child**

Child's Name: \_\_\_\_\_

First Last Mi

Nickname: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Phone #: ( \_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Child lives with: Mother Father Step-Parent Other \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Last Visit \_\_\_\_\_

**Person Responsible For Account**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip

Years There \_\_\_\_\_ Own Home \_\_\_ Rent Home \_\_\_

Birthdate: \_\_\_\_\_ E-mail: \_\_\_\_\_

S.S. # \_\_\_\_\_ Phone #: (H) \_\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (Wk/Cell) \_\_\_\_\_

**Who Is Accompanying Your Child Today?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child? Y N

Whom may we thank for referring you? \_\_\_\_\_

List any family members seen by us ( past or present)

**Orthodontic Insurance  
Primary**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Policy Owner's SS/ID#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Is the patient covered by another Orthodontic Policy? Y N

**Secondary**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Policy Owner's SS/ID#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

**Parental Information**

**Mother**

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Phone #:(H) \_\_\_\_\_ (Wk/Cell) \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Years of Service? \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Partnered

**Father**

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Phone #:(H) \_\_\_\_\_ (Wk/Cell) \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Years of Service? \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Partnered

## Dental and Medical History

|  |  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
|--|--|-------------------------------|----------------------------|--------------------------------|----------------|-------------------------|-----------------------------|------------------------------------|---------------------------|------------|--------------|----------------------------|---------------------------|-----------------------------|-----------------------------|--------------|------------------|---------------------------|--------------------------|--------------------------------|------------------------------|----------------------------|-----------------------------|----------------------|----------------------|-------------------------|--------------------------------|------------------------------|---------------------------|------------------------|---------------------|---------------------|-------------------|-----------------|--------------------|---|--|
| <p>What would you like orthodontics to accomplish for your child?<br/>_____</p> <p>Has your child ever been evaluated or had orthodontic treatment before? <span style="float: right;">Y N</span></p> <p>Have there been any injuries to the face, mouth, teeth or chin? <span style="float: right;">Y N</span></p> <p>Does your child require antibiotics before dental treatment? <span style="float: right;">Y N</span></p> <p>Does your child have any missing or extra permanent teeth? <span style="float: right;">Y N</span></p> <p>Does your child brush his/her teeth daily? <span style="float: right;">Y N</span> Floss daily? <span style="float: right;">Y N</span></p> <p>Has your child ever had any pain/tenderness in the jaw joint? <span style="float: right;">Y N</span></p> <hr/> <p>Child's Physician: _____ City: _____</p> <p>Is your child currently under the care of a physician? <span style="float: right;">Y N</span></p> <p>Has puberty begun? <span style="float: right;">Y N</span> <u>Girls</u>: Has menstruation begun? <span style="float: right;">Y N</span></p> <p>Please describe child's current physical health: Good Fair Poor</p> <p>Please list all drugs your child is currently taking: _____<br/>_____</p> <p>Does your child have allergies to any of the following?<br/>Latex <span style="float: right;">Y N</span> Nickel/Metals <span style="float: right;">Y N</span> Plastic <span style="float: right;">Y N</span></p> <p>Please list any other allergies that the child may have: _____<br/>_____</p> <p>Has your child ever taken any diet pills such as Phen-Fen? <span style="float: right;">Y N</span></p> <p>(Also known as Redux or Pondimin) If so, when? _____</p> <p>Please list any serious medical problems your child has had: _____</p> | <p style="text-align: center;">Are any of the following conditions present?<br/>Please circle yes or no, if yes circle the condition.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Y N Abnormal Bleeding /Anemia</td> <td style="width: 50%; border: none;">Y N Heart Murmur/Pacemaker</td> </tr> <tr> <td style="border: none;">Y N ADD/ADHD/Learning Disabled</td> <td style="border: none;">Y N Hemophilia</td> </tr> <tr> <td style="border: none;">Y N AIDS/HIV+/Hepatitis</td> <td style="border: none;">Y N High/Low Blood Pressure</td> </tr> <tr> <td style="border: none;">Y N Artificial Bones/Joints/Valves</td> <td style="border: none;">Y N Kidney/Liver Problems</td> </tr> <tr> <td style="border: none;">Y N Asthma</td> <td style="border: none;">Y N Leukemia</td> </tr> <tr> <td style="border: none;">Y N Cancer/Chemo/Radiation</td> <td style="border: none;">Y N Mitral Valve Prolapse</td> </tr> <tr> <td style="border: none;">Y N Congenital Heart Defect</td> <td style="border: none;">Y N Rheumatic/Scarlet Fever</td> </tr> <tr> <td style="border: none;">Y N Diabetes</td> <td style="border: none;">Y N Tuberculosis</td> </tr> <tr> <td style="border: none;">Y N Drug/Alcohol Problems</td> <td style="border: none;">Y N Psychiatric Problems</td> </tr> <tr> <td style="border: none;">Y N Epilepsy/Seizures/Fainting</td> <td style="border: none;">Y N Tonsils/Adenoids Removed</td> </tr> <tr> <td style="border: none;">Y N Handicaps/Disabilities</td> <td style="border: none;">Y N Use of Tobacco Products</td> </tr> <tr> <td style="border: none;">Y N Hearing Impaired</td> <td style="border: none;">Y N Venereal Disease</td> </tr> <tr> <td style="border: none;">Y N Heart Attack/Stroke</td> <td style="border: none;">Y N Visually Impaired/Glaucoma</td> </tr> </table> <hr/> <p style="text-align: center;">Has your child ever experienced any of the following?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Y N Clenching/Grinding Teeth</td> <td style="width: 50%; border: none;">Y N Nursing/Bottle Habits</td> </tr> <tr> <td style="border: none;">Y N Lip Sucking/Biting</td> <td style="border: none;">Y N Speech Problems</td> </tr> <tr> <td style="border: none;">Y N Mouth Breathing</td> <td style="border: none;">Y N Tongue Thrust</td> </tr> <tr> <td style="border: none;">Y N Nail Biting</td> <td style="border: none;">Y N Pacifier Usage</td> </tr> <tr> <td colspan="2" style="border: none;">Y N Thumb/Finger Sucking: Age Stopped _____</td> </tr> </table> <p>Other condition not listed above that you feel we should know about: _____<br/>_____<br/>_____</p> | Y N Abnormal Bleeding /Anemia | Y N Heart Murmur/Pacemaker | Y N ADD/ADHD/Learning Disabled | Y N Hemophilia | Y N AIDS/HIV+/Hepatitis | Y N High/Low Blood Pressure | Y N Artificial Bones/Joints/Valves | Y N Kidney/Liver Problems | Y N Asthma | Y N Leukemia | Y N Cancer/Chemo/Radiation | Y N Mitral Valve Prolapse | Y N Congenital Heart Defect | Y N Rheumatic/Scarlet Fever | Y N Diabetes | Y N Tuberculosis | Y N Drug/Alcohol Problems | Y N Psychiatric Problems | Y N Epilepsy/Seizures/Fainting | Y N Tonsils/Adenoids Removed | Y N Handicaps/Disabilities | Y N Use of Tobacco Products | Y N Hearing Impaired | Y N Venereal Disease | Y N Heart Attack/Stroke | Y N Visually Impaired/Glaucoma | Y N Clenching/Grinding Teeth | Y N Nursing/Bottle Habits | Y N Lip Sucking/Biting | Y N Speech Problems | Y N Mouth Breathing | Y N Tongue Thrust | Y N Nail Biting | Y N Pacifier Usage | Y N Thumb/Finger Sucking: Age Stopped _____ |  |
| Y N Abnormal Bleeding /Anemia  | Y N Heart Murmur/Pacemaker   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N ADD/ADHD/Learning Disabled   | Y N Hemophilia   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N AIDS/HIV+/Hepatitis  | Y N High/Low Blood Pressure  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Artificial Bones/Joints/Valves   | Y N Kidney/Liver Problems  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Asthma   | Y N Leukemia   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Cancer/Chemo/Radiation   | Y N Mitral Valve Prolapse  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Congenital Heart Defect  | Y N Rheumatic/Scarlet Fever  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Diabetes   | Y N Tuberculosis   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Drug/Alcohol Problems  | Y N Psychiatric Problems   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Epilepsy/Seizures/Fainting   | Y N Tonsils/Adenoids Removed   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Handicaps/Disabilities   | Y N Use of Tobacco Products  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Hearing Impaired   | Y N Venereal Disease   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Heart Attack/Stroke  | Y N Visually Impaired/Glaucoma   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Clenching/Grinding Teeth   | Y N Nursing/Bottle Habits  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Lip Sucking/Biting   | Y N Speech Problems  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Mouth Breathing  | Y N Tongue Thrust  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Nail Biting  | Y N Pacifier Usage   |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |
| Y N Thumb/Finger Sucking: Age Stopped _____  |  |                               |                            |                                |                |                         |                             |                                    |                           |            |              |                            |                           |                             |                             |              |                  |                           |                          |                                |                              |                            |                             |                      |                      |                         |                                |                              |                           |                        |                     |                     |                   |                 |                    |   |  |

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

|  |   |
|--|---|
| <p>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.</p> <hr/> <p><b>SIGNATURE-RESPONSIBLE PERSON LISTED ON FRONT</b> <span style="float: right;"><b>DATE</b></span></p> <p>__ Employed __ Retired __ Unemployment Comp __ None __ Other</p> <p><b>Occupation</b> __ Professional __ Sales/Admin __ Trade/Tech<br/>__ None __ Service __ Military Officer __ Enlisted</p> | <p style="text-align: center;">_____<br/>SIGNATURE OF PARENT OR GUARDIAN <span style="float: right;">DATE</span></p> <hr/> <p>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 my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.</p> <p style="text-align: center;">_____<br/>SIGNATURE OF PARENT OR GUARDIAN <span style="float: right;">DATE</span></p> |
|--|---|

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

## Medical History Update (For later use)

|  |   |
|--|---|
| <p>Has there been any change in your child's health status since their last visit? <span style="float: right;">Y N</span></p> <p>If yes, please explain: _____<br/>_____</p> | <p style="text-align: center;">_____<br/>PARENT/GUARDIAN SIGNATURE <span style="float: right;">DATE</span></p> <hr/> <p style="text-align: center;">_____<br/>WITNESS <span style="float: right;">DATE</span></p> |
| <p>Has there been any change in your child's health status since their last visit? <span style="float: right;">Y N</span></p> <p>If yes, please explain: _____<br/>_____</p> | <p style="text-align: center;">_____<br/>PARENT/GUARDIAN SIGNATURE <span style="float: right;">DATE</span></p> <hr/> <p style="text-align: center;">_____<br/>WITNESS <span style="float: right;">DATE</span></p> |