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 _____

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)

_____

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

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) _____

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: _____

Dental and Medical History

What would you like orthodontics to accomplish for your child?

_____

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Does your child require antibiotics before dental treatment? Y N

Does you child have any missing or extra permanent teeth? Y N

Does your child brush his/her teeth daily? Y N Floss daily? Y N

Has your child ever had any pain/tenderness in the jaw joint? Y N

Child's Physician: _____ City: _____

Is your child currently under the care of a physician? Y N

Has puberty begun? Y N Girls: Has menstruation begun? Y N

Please describe child's current physical health: Good Fair Poor

Please list all drugs your child is currently taking: _____

_____

Does your child have allergies to any of the following?

Latex Y N Nickel/Metals Y N Plastic Y N

Please list any other allergies that the child may have: _____

_____

Has your child ever taken any diet pills such as Phen-Fen? Y N

(Also known as Redux or Pondimin) If so, when? _____

Please list any serious medical problems your child has had: _____

Are any of the following conditions present?

Please circle yes or no, if yes circle the condition.

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

Has your child ever experienced any of the following?

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 _____

Other condition not listed above that you feel we should know about: _____

_____

_____

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.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

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-RESPONSIBLE PERSON LISTED ON FRONT **DATE**

__ Employed __ Retired __ Unemployment Comp __ None __ Other

Occupation ___ Professional ___ Sales/Admin ___ Trade/Tech

___ None___ Service ___ Military Officer ___ Enlisted

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.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

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)

Has there been any change in your child's health status since their last visit? Y N

If yes, please explain: _____

_____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

WITNESS DATE

Has there been any change in your child's health status since their last visit? Y N

If yes, please explain: _____

_____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

WITNESS DATE