

Child Information Form



WELCOME

To assist us in providing the most complete service, please provide the following information and health history.

DAVID C. HAMILTON, JR.
DDS, MS, PA

Chart # _____

Date _____

PERSONAL INFORMATION

Name _____
First Middle Last Nickname _____

Sex _____ Age _____ Date of birth _____ School _____ Grade _____
Mo. Day Yr.

Brothers/Sisters (Name and Age) _____

Dentist _____ Physician _____

Referred by _____

MOTHER

FATHER

Name _____

Name _____

Address _____

Address _____

(If different)

Home phone _____

Home phone _____

Mobile phone _____

Mobile phone _____

Employed by _____

Employed by _____

Work phone _____

Work phone _____

Birthdate: ____/____/____ SS#: _____

Birthdate: ____/____/____ SS#: _____

Marital Status _____

Marital Status _____

Parent's email address _____

Parent's email address _____

Person Responsible For Account _____

PRIMARY DENTAL INSURANCE ONLY

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes No If "Yes" complete below

Ortho coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Insurance Co. Phone #: (____) _____

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

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

Policy Owner's Name: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Policy Owner's Employer: _____

FOR OFFICE USE ONLY

Insurance Verification	Lifetime Max _____	How much Met? _____	Claim Address: _____
Date: _____	How to bill: Mos _____	Qtr. _____	6 mos _____
Effect Date: _____	Payer I.D. _____		_____
Ded: _____	Carrier # _____		_____

DAVID C. HAMILTON, JR., DDS, MS, PA
Member American Association of Orthodontists
Diplomate American Board of Orthodontics

322 10th Ave. Drive NE
Hickory, NC 28601
Phone 828.324.4535 • Fax 828.324.8748
Website: www.hickorysmile.com

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Please check box if patient has or has had:

- Positive HIV test
- Joint swelling
- Bone disorders
- Heart trouble
- Rheumatic fever
- Thyroid problems
- Diabetes
- Hepatitis
- Emotional problems
- Brain injury
- Kidney or liver involvement
- Tuberculosis
- Anemia
- Asthma
- Epilepsy
- Prolonged bleeding
- Faintness/Dizziness
- Tonsils removed
- Adenoids removed
- Sore throats
- Tonsillitis
- Earaches

List any other serious illnesses: _____

List any allergies: _____

List drugs or medications now being taken: _____

Do you smoke or use tobacco products? Yes No

Is patient under physician's care presently? _____

Reason: _____

Name of physician: _____

Approximately how much has patient grown in the last year? _____

Additional comments: _____

DENTAL HISTORY

Please check box if answer is yes:

- Any injuries to face, mouth, teeth? (circle)
- Thumb, finger, lip sucking? (circle)
- Mouth-breathing when asleep, awake? (circle)
- More than average amount of decay?
- Any missing permanent teeth?
- Any extra permanent teeth?
- Any teeth removed by extraction?
- Is there any tongue-thrusting problem?
- Any speech problems?
- Any difficulty in swallowing or chewing?
- Any pain or clicking on opening mouth?
- Is patient adopted? At what age? _____
- Does patient visit dentist regularly?
Date of last dental visit _____
- Has an orthodontist been consulted previously?
Reason: _____

List any wind instrument played: _____

Sports: _____ Hobbies: _____

Other family members treated: _____

GIRLS ONLY

Has the patient started her monthly periods? Yes No DK/U Is the patient pregnant? Yes No DK/U
 If so, approximately when? _____

Please note any other factors the doctor should know about the patient's dental health: _____

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.) _____

Please describe your reasons for considering orthodontic treatment.

- Improved facial appearance
- Improved functional health
- Enhanced long-term dental health
- Other _____

Please describe your child's attitude toward orthodontic treatment.

- Wants it done
- Does not want it done
- Does not care

PATIENT AUTHORIZATION - PLEASE SIGN BELOW

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.

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 the office, use the services of one or more credit reporting services.

X _____
Signature of parent or guardian Date

I authorize the dental staff to perform the necessary dental services my child may need.

X _____
Signature of parent or guardian Date

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.

X _____
Signature of parent or guardian Date