HAMILTON & HERRING
Orthodontics

# WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1 Tell Us About Your Child

Today's Date:____________ Nickname:______________

**Child's Name:** ________________________
LAST FIRST MI

Birthdate:____/____/____ Age:________ ☐ Male ☐ Female

School:______________________ Grade:__________

Hobbies / Sports:______________________________

Child's Home #: (____)__________________________

**Child's Home Address:** ______________________
APT/CONDO #

________________________________________
CITY STATE ZIP

## 2 Who is Accompanying Your Child Today?

Name:__________________ Relation:______________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you?____________

List brothers / sisters with age:________________

________________________________________

General Dentist:_________________________________

Last Visit Date:_________________________________

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

## 3

☐ **Mother's Information** ☐ Step Mother ☐ Guardian

Name:______________________ Birthdate:____/____/____

Wk #: (____)__________ Ext:_____ Hm #:(____)__________

Address:________________________________________

Cell #:__________________ SS #__________________

Email:__________________________________________

☐ **Father's Information** ☐ Step Father ☐ Guardian

Name:______________________ Birthdate:____/____/____

Wk #: (____)__________ Ext:_____ Hm #:(____)__________

Address:________________________________________

Cell #:__________________ SS #__________________

Email:__________________________________________

## 4 Person Responsible For Account

Name:____________________ Relation:______________

Billing Address:_________________________________

________________________________________
CITY STATE ZIP

Previous Address:________________________________

________________________________________
CITY STATE ZIP

Hm #: (____)____________________________________

Employer:_______________________________________

Wk #: (____)__________ Ext:______ SS #:__________

**Who is responsible for making appointments?**

Name:___________________________________________

Wk #: (____)__________ Ext:_____ Hm #:(____)__________

## 5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:______________________________

Insurance Co. Address:___________________________

Insurance Co. Phone #: (____)____________________

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

**Policy Owner's** Name:__________________________

Relationship to Patient:_________________________

**Policy Owner's** Birthdate:____/____/____ ID #:__________

**Policy Owner's** Employer:______________________

Employer's Address:______________________________

### Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:______________________________

Insurance Co. Address:___________________________

Insurance Co. Phone #: (____)____________________

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

Policy Owner's Name:_____________________________

Relationship to Patient:_________________________

Policy Owner's Birthdate:____/____/____ ID #:__________

Policy Owner's Employer:_________________________

Employer's Address:______________________________

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## 6

What are the main concerns that you would like orthodontics to accomplish? ____________

Has your child ever had any of the following:

| | | |
|---|---|---|
| Prior orthodontic evaluation or treatment | Y | N |
| Serious/difficult problem with previous dental treatment | Y | N |
| Injuries to the face, mouth, chin or teeth | Y | N |
| Tonsils or adenoids removed | Y | N |
| Missing or extra permanent teeth | Y | N |
| Pain/tenderness/restricted movement of the jaw joints | Y | N |

Does your child brush teeth daily? Y N Floss daily? Y N

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor Explain ____________

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

Physician name: ____________

Phone: ____________ Last visit: ____________

Has your child begun puberty? Y N

For girls, has menstruation begun? Y N

If so, when? ____________

Please list any medications that your child is currently taking:

____________

____________

Please list any musical instruments played: ____________

**Is your child allergic to any of the following?**

| | | |
|---|---|---|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metals/Plastics | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

Please list any other drugs/materials that your child is allergic to: ____________

____________

## 7 Has your child ever had any of the following medical problems?

| | |
|---|---|
| Y N Abnormal Bleeding | Y N Convulsions / Epilepsy |
| Y N ADD / ADHD | Y N Diabetes |
| Y N Allergies to any Drugs | Y N Handicaps / Disabilities |
| Y N Allergic to Latex / Metals | Y N Hearing Impairment |
| Y N Allergic to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Artificial Bones / Joints / Valves | Y N HIV+ / AIDS |
| | Y N Kidney / Liver Problems |
| Y N Asthma | Y N Lupus |
| Y N Cancer | Y N Rheumatic / Scarlet Fever |
| Y N Congenital Heart Defect | Y N Tuberculosis (TB) |

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

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## 8 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 Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

Neighbor or Relative not living with you.

Name ____________ Phone (____) ____________

Address ____________

CITY STATE ZIP

## 9

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

____________

Signature of parent or guardian Date

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

____________

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. I hereby authorize payment of the group insurance benefits directly to this office.

____________

Signature of parent or guardian Date

**The Parent or Guardian who accompanies the child is responsible for payment.**

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.

## OFFICE USE ONLY

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

**Doctor's Comments:** Initials: ____________ Date: ____________

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