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Office: (509) 962-6902

Child Patient Information (under 18 years)

Patient's Name _____ Today's Date _____
Mailing Address _____ City _____ State _____ Zip _____
Nickname _____Birth Date____/_____/_____ Age_____ ❑M ❑F
Grade _____ School _____Dentist _____
Whom may we thank for referring you to our office? _____
COURTESY REMINDERS: ❑Text Number(s): _____ ❑Email: _____

Responsible Party Information

Name _____ ____❑Single ❑Married ❑ Widowed ❑Divorced ❑Separated
Mailing Address _____City _____ State _____ Zip _____ Yrs ____
Email Address: _____
Home Phone _____Work Phone _____Cell Phone_____
Social Security Number ____- ____-_____ Birth Date _____/_____/_____ Relationship to Patient _____
Employer _____ Occupation _____ No. years employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. years employed _____
Social Security Number ____- ____-_____ Birth Date _____/____/___Work Phone _____

Dental Insurance Information

Insured's Name _____ ____ Birth Date _____/_____/____ SSN _____ - _____ - _____
Insurance Company _____ Group No. _____ Phone No. _____
Do you have dual coverage? Yes _____ No: _____ If yes:
Insured's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____
Insurance Company _____Group No. _____ Phone _____

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company. **Office Policy: Your Social Security Number will need to be on file should you decide to finance through our office.

Emergency Contact Information

Name of nearest relative not living with you _____Phone_____

Please continue to the back

Dental History

What is your chief concern? _____

_____

Are you interested in: (please indicate all that apply)

❑ Information ❑ Treatment now ❑ Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? ❑ Yes ❑ No
2. Does the patient have any speech problems? ❑ Yes ❑ No
3. Has the patient ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
4. Has any previous orthodontic treatment been rendered? ❑ Yes ❑ No
5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.? ❑ Yes ❑ No
6. Have you ever observed your child has any habits? ❑ Thumb/finger sucking ❑ Mouth breathing ❑Tongue thrust

Other:_____

_____

Medical History

Name of your physician _____ Date of last exam_____

1. Is the patient in good health? ❑Yes ❑No

   If no, explain_____

3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)?

❑Yes ❑No If yes, please list: _____

4. Please list any current prescription medications: _____
5. Has the patient had any recent rapid growth ❑Yes ❑No ❑Early? ❑Late? Females: Has menstruation begun? ❑Yes ❑ No

   If yes, when? _____ Pregnant? ❑Yes ❑ No

6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

❑ Problems at Birth	❑ Hepatitis/Liver Disease	❑ Seizures
❑ Heart Disease/Murmur	❑ Tuberculosis	❑ Cleft Lip/Palate
❑ Rheumatic Fever	❑ Kidney Disease	❑ Speech or Hearing Problems
❑ Sickle Cell Anemia	❑ Cancer/Radiation Therapy	❑ Tonsil, Adenoid, Sinus Problems
❑ Anemia/Hemophilia	❑ Cerebral Palsy	❑ Emotional/Behavior Problems
❑ Diabetes	❑ Arthritis	❑ Learning Disabilities
❑ AIDS or HIV	❑ Asthma	❑ Growth Problems

Other:_____

_____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. 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.

_____ _____

Responsible party signature Date