Welcome to the Orthodontist!

Today's Date: ___/___/____

We would like to welcome you to Hardy Orthodontics! Please fill out the form below and bring it with you to your child's first appointment.

Child's Name: _____ Nickname: _____
Last First MI

□ Male □ Female Child's Birthdate: ___/___/____ Age: ____ Home #: _____

Home Address: _____
Street Apt# City State Zip

E-Mail Address_____

School: _____ Grade: _____

Hobbies/Sports: _____

Whom may we thank for referring you? _____

General Dentist:_____ Last Visit Date: ___/___/____

Mother's Information: □ Stepmother □ Guardian

Name: _____ Birthdate: ___/___/____

Social Security #: _____ Phone #: _____

Employer: _____ Work #: _____

Father's Information: □ Stepfather □ Guardian

Name: _____ Birthdate: ___/___/____

Social Security #: _____ Phone #: _____

Employer: _____ Work #: _____

Parent's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Child lives with: _____

Person Responsible for this Account: _____ SS#: _____

Billing Address: _____
Street Apt# City State Zip

Primary Orthodontic Insurance:

Orthodontic Coverage? □ Yes □ No Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

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

Secondary Orthodontic Insurance:

Orthodontic Coverage? □ Yes □ No Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

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

Policy Owner's Employer: _____

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

_____ _____

Has your child ever been evaluated for or had orthodontic treatment before? □ Yes □ No
Have there been any injuries to the face, mouth, teeth or chin? □ Yes □ No
Have adenoids or tonsils been removed? □ Yes □ No

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

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment	Y	N	Clenching/Grinding Teeth
Y	N	Allergies to any Drugs	Y	N	Heart Murmur	Y	N	Lip Sucking/Biting
Y	N	Allergies to Latex/Metals	Y	N	Hepatitis	Y	N	Mouth Breather
Y	N	Asthma	Y	N	HIV+/AIDS	Y	N	Nail Biting
Y	N	Cancer	Y	N	Kidney/Liver Problems	Y	N	Speech Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever	Y	N	Thumb/Finger Sucking
Y	N	Convulsions/Epilepsy	Y	N	Tuberculosis (TB)	Y	N	Tongue Thrust
Y	N	Diabetes						

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

_____

Child's Physician: _____ Phone #: _____

Date of Last Visit: ___/___/____ Is your child currently under the care of a physician? □ Yes □ No

Has puberty begun? □ Yes □ No Has menstruation begun? (Girls) □ Yes □ No

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

Please list all drugs your child is currently taking: _____

_____

Please list all drugs your child is allergic to: _____

_____

- This office reserves the right to verify the credit status of patients prior to extending credit for treatment fees.
- I understand that the information 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 medical status.

Signature: _____ Date: ___/___/____

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