

Douglas N. Smith, DMD, MDS

BOARD CERTIFIED ORTHODONTIST

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1. Please enter the child's information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Social security number: _____ Gender: _____
 Female Male

Home address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: _____
 Mobile Phone Home Phone Work Phone
 Email

School: _____ Grade: _____

2. List any sports or extracurricular activities:

3. Siblings (names and ages):

	Name	Age		Name	Age
1			2		

4. Parent Information:

Parent/guardian name: _____ Relationship: _____

Parents' marital status: _____ Social security number: _____ Birth date: _____
 Single Married Domestic Partner
 Separated Divorced Widowed

Driver's license number: _____ Phone number: _____ Phone type: _____
 Cell Home Work

Parent/guardian address (if different than child's): _____ Apt./Unit #: _____

Employer's name: _____ Occupation: _____

5. Parent Information:

Parent/guardian name: _____ Relationship: _____

Parents' marital status: _____ Social security number: _____ Birth date: _____
 Single Married Domestic Partner
 Separated Divorced Widowed

Driver's license number: _____ Phone number: _____ Phone type:
 Cell Home Work

Parent/guardian address (if different than child's): _____ Apt./Unit #: _____

Employer's name: _____ Occupation: _____

6. Emergency Contact Information:

Emergency contact name: _____ Relationship to patient: _____ Emergency contact number: _____

Emergency contact address: _____ Apt./Unit #: _____

7. Person(s) OK to release appointment or medically related information to concerning child:

	Name	Relationship		Name	Relationship
1			2		

8. Primary Insurance Information:

Primary insurance company: _____ Phone: _____

Group number: _____ Policy number: _____

Policy holder's name: _____ Relationship: _____ Date of birth: _____

Employer: _____ Work phone number: _____

Social security number: _____ Co-pay (if known): _____ Deductible (if known): _____

9. Would you like to add Secondary Insurance?

Yes

No

10. Secondary Insurance Information:

Secondary insurance company: _____ Phone: _____

Group number: _____ Policy number: _____

Policy holder's name: _____ Relationship: _____ Date of birth: _____

Employer: _____ Work phone number: _____

Social security number: _____ Co-pay (if known): _____ Deductible (if known): _____

11. General dentist name: _____ **Last visit:** _____

12. How did you hear about our practice?

- Internet Family/friend Dentist
 Ad Other:

If other, please specify:

13. Who referred you (if applicable)?

14. What are the main concerns/goals you would like orthodontics to address/accomplish?

15. Has your child visited an orthodontist before?

- Yes
 No

16. If so, when and for what reason?

17. Have we treated any other family members? (If so, please list names.)

18.	Yes/No	If Yes, please explain:
Have your child's tonsils or adenoids been removed?		
Has your child ever experienced jaw joint pain/ discomfort (TMJ/TMD)?		
Does your child have any missing or extra permanent teeth?		
Does your child have speech problems?		
Do your child's gums bleed?		
Does your child smoke? (state #/day)		
Does your child like his/her smile (If no, please explain)		

19. Has your child ever had an injury to (select all that apply):

- Teeth
 Mouth
 Chin
 None

20. Please explain any injury noted above:

21. Does your child currently or have they ever had any of the following habits (check all that apply)

- Clenching/Grinding Teeth
 Lip Sucking/Biting
 Mouth Breathing
 Nail Biting
 Thumb/Finger Sucking
 Chewing/Eating Problem

22. Is your child currently being treated by a physician?

- Yes
 No

23. If your child is currently being treated by a physician:

Reason:

Physician name:

Date of last visit:

Physician phone:

24. Does your child have any allergies/sensitivities to medications or latex?

- Yes
- No

25. If yes, please list:

26. Is your child currently taking any prescription or over-the-counter medications?

- Yes
- No

27. Please list any Prescription or over the counter medications your child is taking:

	Medication Name	Dosage	Reason for Taking?
1			
2			
3			

28. Has puberty and/or menstruation begun?

- Yes
- No
- N/A

29. Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?

- Yes
- No

30. Has your child had any serious illnesses or operations?

- Yes
- No

31. Please list any serious illnesses or operations:

32. Has your child ever had a blood transfusion?

- Yes
- No

If yes, give approximate dates:

33. Is your child:

Pregnant?

- Yes
- No

Nursing?

- Yes
- No

Taking birth control?

- Yes
- No

34. Check if your child has or has ever had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial heart valves |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Cortisone treatments |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Rheumatic fever | |

35. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office.

I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Parent/Guardian Signature

Signature

Date