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: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Social security number: _____ Birth date: _____

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:
☐ Single ☐ Married ☐ Domestic Partner
☐ Separated ☐ Divorced ☐ Widowed

Social security number: Birth date:

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 lonimin, 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?	Nursing?	Taking birth control?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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