



Margaret Zadnik-O'Connell, DDS | Members American Association of Orthodontists

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Tell Us About Your Child

Today's Date: _____ Male Female
Child's Name: _____
Last First M
Nickname: _____
Child's Home Address: _____
Apt/Condo #
City State Zip
Child's Home #: _____
Child's Birthdate: _____ Child's Age: _____
School: _____ Grade: _____

Whom may we Thank for referring you? _____

List brothers/sisters with age:

Were they treated by this office? _____

GENERAL DENTIST: _____

Address: _____
Town: _____
Phone #: _____
Last Visit Date: _____

Primary Orthodontic Insurance

Orthodontic Coverage? Yes No Dental Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Phone #: _____
Group # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: _____
Policy Owner's SS#/ID#: _____
Policy Owner's Employer: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____
Do you have legal custody of this child? _____ Yes No
Parents' Marital Status: Single Married Widowed Divorced Separated
Mother's Information: Stepmother Guardian
Name: _____ Birthdate: _____
Home #: _____ Work #: _____
Cell #: _____
SS #: _____
Email: _____
Employer: _____

Father's Information: Stepfather Guardian
Name: _____ Birthdate: _____
Home #: _____ Work #: _____
Cell #: _____
SS #: _____
Email: _____
Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? Yes No Dental Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Phone #: _____
Group # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: _____
Policy Owner's SS#/ID#: _____
Policy Owner's Employer: _____

What are the main goals that you would like to 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

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

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

(Girls) Has menstruation begun? Yes No

Please describe your child's physical health:
 Good Fair _____

Please list all drugs that your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____

Do we have your permission to display your child's before and after pictures on our bulletin board?
 Yes No

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

OFFICE USE ONLY

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

Doctor's Comments:

Initials: _____ Date: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Latex/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

Has your child ever had any of the following habits?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |

Authorization

I certify that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment, with my informed consent.

Signature: _____ Date: _____

HIPAA Acknowledgement

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. I understand that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature: _____
Patient, parent or legal guardian

Date: _____

If signed by a patient representative, state relationship to patient:
