RICK BURNS ORTHODONTICS

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

Birth date: ____________ Age: _____ ☐ M ☐F

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home # (_____)_____

Child's Home Address: _____

_____
CITY STATE ZIP

E-mail Address:_____

2 Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List other family members seen by us: _____

_____

General Dentist: _____

Date of last cleaning / visit: _____

3 Parental Information

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Widowed ☐ Married ☐ Separated ☐ Divorced

☐ Mother ☐ Stepmother ☐ Guardian

Name: _____ Birth date:____________

Wk # (_____)_____ Hm # (_____)_____

Employer: _____

How long at current job: _____ Job Title: _____

SS# _____ DL# _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____ Birth date:____________

Wk # (_____)_____ Hm # (_____)_____

Employer: _____

How long at current job: _____ Job Title: _____

SS# _____ DL# _____

4 Person Responsible For Account If Other Than #3

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Hm # (____)_____ DL # _____

Employer: _____

Wk # (____)_____ SS #: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# (_____)_____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

SS#: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# (_____)_____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

SS#: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

6

What would you like orthodontics to accomplish?

_____

_____

Has your child ever been evaluated 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

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

Child's Physician: _____

Phone # (_____)_____ Date of last visit: _____

Is your child under the care of a physician? Yes No

Has Puberty begun? Yes No

Girls – Has menstruation begun? Yes No

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

Please list all drugs that your child is currently taking:

_____

_____

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

_____

_____

Latex Y N Medals/Nickel Y N Plastics Y N

7

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

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairments
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Artificial Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic/Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)
Y	N	Taken Phen-Fen (Redux or Pondimin)			

Please discuss any medical problems that your child has experienced:

_____

_____

_____

_____

8

Has your child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing / Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental / orthodontic services that my child may need during diagnosis and treatment.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I herby authorize payment of group insurance benefits directly to this office.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

The parent or Guardian who accompanies the child is responsible for payment.

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

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient / guardian and patient named herein. ☐ _____ Initial

Doctor's Comments: _____

_____ Date_____