Welcome

To Sherman Orthodontics

Today's Date:_____

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Child's Name:_____
Last First M. Ini.
Child's Birthdate: _____ Age _____
Preferred Name:_____ ❑ Male ❑ Female
School:_____ Grade:_____
Hobbies/Sports:_____
General Dentist:_____
Last Exam Date:_____Any cavities?_____
Primary Contact#: ( )_____
Child's Home Address:_____
_____
City State Zip
Email for appointment reminders: _____

2 Who Is Accompanying The Child Today?

Name:_____ Relation:_____
Do you have legal custody of this child? ❑ Y ❑ N
Whom may we Thank for referring you? _____
List brothers/sisters with age:_____
_____
Parent's Marital Status: ❑ Single ❑ Married
❑ Widowed ❑ Divorced ❑ Separated
Who does child reside with? _____
Person responsible for making appointments?_____

3 Parent's Information

Mother ❑ Step Mother ❑ Guardian
Name:_____ DOB:_____
Cell#:( ) _____Hm#:( )_____
Employer:_____
How long at current job?_____ Title:_____
SS#:_____ Email:_____

Father ❑ Step Father ❑ Guardian
Name:_____ DOB:_____
Cell#:( ) _____Hm#:( )_____
Employer:_____
How long at current job?_____Title:_____
SS#:_____Email:_____

4 Person Responsible For Account

Name:_____ Relation:_____
Billing Address:_____
_____
City State Zip
Primary Phone#: ( )_____ cell home wk
Alternate Phone#: ( )_____ cell home wk
Employer:_____
Wk#: ( )_____ Ext._____

5 Primary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No
Insurance Co. Name:_____
Insurance Co. Phone#: ( )_____
Subscriber ID or SS#:_____
Group# (Plan, local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's DOB:_____

6 Does/did the Child Have Any of the Following?

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

Please Fill Out Page Two of This Form

7 What would you like orthodontics to accomplish?

_____

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child even had any pain / tenderness in his / her jaw joint (TMI/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#: ( )_____

Date of Last Visit:_____

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

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

_____

_____

_____

8 Has your child ever had any of the following medical problems:

Y N Abnormal Bleeding

Y N Allergies to Any Drugs

Y N Allergic to Latex/Metals

Y N Allergic to Plastics

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Heart Defect

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Murmur

Y N Hemophilia

Y N Hepatitis

Y N HIV +/ AIDS

Y N Kidney/Liver Problems

Y N Rheumatic/Scarlet Fever

Y N Tuberculosis (TB)

I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of 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 services my child may need.

9

_____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies. If this office accepts insurance, I understand that I am responsible for services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize Sherman Orthodontics to release all information necessary to secure payment of benefits and I assign directly to Sherman Orthodontics all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of parent or guardian Date

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

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____

_____