WELCOME TO CASSALIA ORTHODONTICS

PLEASE FILL OUT THE FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN SERVE YOU.

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

1 Tel us about your child

Todays Date:_____

Name:_____
LAST FIRST MI

Birthdate:___/___/___ Age:_____ ☐ Male ☐ Female

Home #:_____ Cell/Other #:_____

Childs Home Address:

_____

_____
City State Zip

School:_____ Grade_____

Hobbies / Sports:_____

2 Who will be accompanying your child During the consultation appointment?

Name:_____ Relation_____

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

Who may we thank for referring you?_____

Childs General Dentist:_____

Last visit date:_____

Other family members seen by us: _____

_____

Parents Marital Status :

☐ Single ☐ Partnered ☐ Divorced

☐ Married ☐ Separated ☐ Widowed

4 MOTHER'S INFORMATION

☐ Stepmother ☐ Guardian

Name:_____

Email Address:_____ Birthdate:___/___/___

Home #:_____ Cell/Other #:_____

Employer:_____WK #_____

SS#:_____Drivers License #_____

5 FATHER'S INFORMATION

☐ Stepfather ☐ Guardian

Name:_____

EMAIL Address:_____ Birthdate:___/___/___

Home #:_____ Cell/Other #:_____

Employer:_____WK #_____

SS#:_____Drivers License #_____

6 PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relation_____

Billing Address:_____

_____

Home #:_____ Cell/Other #:_____

SS#:_____Drivers License #_____

Employer:_____WK #_____

7 WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name:_____

Home #:_____ Cell/Other #:_____

8 ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:(___)_____

Group # (Plan, Local or Policy #:_____

Policy Owner Name:_____

Relationship to Patient:_____

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

Policy Owner Employer:_____

Employer Address:_____

_____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:(___)_____

Group # (Plan, Local or Policy #:_____

Policy Owner Name:_____

Relationship to Patient:_____

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

Policy Owner Employer:_____

Employer Address:_____

_____

9

Dental History and related information

What is the main concern that you would like orthodontics to accomplish?

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin ☐ Face

List any musical instruments played:_____

Has your child ever experienced pain / discomfort in their jaw joint (TMJ / TMD) ☐ Yes ☐ No

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

Floss his / her teeth daily? ☐ Yes ☐ No

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

Does your child have any speech problems? ☐ Yes ☐ No

Has your child ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

10

Medical History and related information

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

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

Physician's Name:_____

Phone # _____ Date of last visit:_____

Has adenoids or tonsils been removed? ☐ Yes ☐ No

Has Puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please list all drugs that your child is taking:_____

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

Latex ☐ Yes ☐ No Metals / Nickel ☐ Yes ☐ No Plastics ☐ Yes ☐ No

Has your child ever had any of the following medical problems

Abnormal Bleeding	☐ Yes	☐ No		Handicaps / Disabilities	☐ Yes	☐ No	
ADD / ADHD	☐ Yes	☐ No		Hearing Impairment	☐ Yes	☐ No	
Any Hospital Stays	☐ Yes	☐ No		Heart Murmur	☐ Yes	☐ No	
Any Operations	☐ Yes	☐ No		Hemophilia	☐ Yes	☐ No	
Artificial Bones / Joints / valves	☐ Yes	☐ No		Hepatitis	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		HIV / AIDS	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No		Kidney / Liver Problems	☐ Yes	☐ No	
Congenital Heart Defect	☐ Yes	☐ No		Lupus	☐ Yes	☐ No	
Convulsions / Epilepsy	☐ Yes	☐ No		Rheumatic / Scarlet Fever	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		Tuberculosis (TB)	☐ Yes	☐ No	

Please note any medical problems that your child has had:

_____

_____

_____

THANK YOU FOR FILLING OUT THIS FROM COMPLETELY.

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 and/or dental status.
I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guarding 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 the office, use the services of one or more credit reporting services.

_____ _____
Signature of parenting or guarding Date

If this office accepts your 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 hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of parent or guarding Date