UNDER 19

WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best possible service, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name ______________________ ______________________ ______________
Last First Middle

Address ______________________ ______________ ________ __________
Street City State Zip

Birthdate ______________ MM-DD-YYYY E-mail ______________ Social Security # ______________ 999-99-9999

Home Phone ______________ 999-999-9999 General Dentist ______________ Last Visited ______________

Who may we thank for referring you to our office?______________________

Parents Information

Father

Name ______________________ ______________________ ______________
Last First Middle

Address ______________________ ______________ ________ __________
Street City State Zip

Birthdate ______________ MM-DD-YYYY E-mail ______________ Social Security # ______________ 999-99-9999

Home Phone ______________ 999-999-9999 Cell Phone ______________ 999-999-9999 Work Phone ______________ 999-999-9999 ext. ________

Employer ______________ Occupation ______________ No. Years Employed ________

Relationship to Patient ______________ Are you married or separated?__________

Mother

Name ______________________ ______________________ ______________
Last First Middle

Address ______________________ ______________ ________ __________
Street City State Zip

Birthdate ______________ MM-DD-YYYY E-mail ______________ Social Security# ______________ 999-99-9999

Home Phone ______________ 999-999-9999 Cell Phone ______________ 999-999-9999 Work Phone ______________ 999-999-9999 ext. ________

Employer ______________ Occupation ______________ No. Years Employed ________

Relationship to Patient ______________

Insurance Information

Policy Owner's Name ______________ Policy Owner's Employer ______________

Insurance Company ______________ Group No. (plan, local, or policy) ______________

Insurance Co. Address______________ Insurance Phone No. ______________

Do you have Dual Coverage? Yes No

General Information

School ______________________________

Hobbies

Brothers/Sisters (include ages)

Medical History

Medical Physician ____________________ Phone ____________ Last Visit ____________

Is the child currently under the care of a physician? Yes No If yes, please explain ______________________

Has puberty begun? Yes No Has menstruation (period) begun? Yes No N/A

What are the main concerns that you would like orthodontics to accomplish?______________________

Has the patient ever been evaluated for orthodontic treatment? ______________________

Has the patient tonsils or adenoids been removed? Yes No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to : (select all that apply) Teeth Mouth Chin

Any of these occurring?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Does the patient have speech problems? Yes No If yes, please explain ______________________

Any allergies?

Aspirin
Erythromycin
Codeine
Penicillin
Tetracycline
Latex
Any Metals/Plastics

Other:

____

List all drugs the Patient is currently taking

List any serious medical condition(s)

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it 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 hereby authorize the release of any information related to insurance claims.
I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained. I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

Signature______________________________ Date ______________

If you would like to be considered for all types of financing, please provide the added information:
How long have you been at current address?____________Do you own or rent?____________

Previous address (if less than 3 years)______________________Marital Status________

Additional Helpful Info

Do you have any experience with orthodontic treatment? ie have you had yourself or have any of your kids had orthodontic treatment? If so, please explain:

What is your timeline to begin orthodontic treatment?
1. As soon as possible, I know it is needed.
2. Depends on Doctor's recommendation, but I am ready if needed.
3. I will need some time, if the Doctor feels it is needed, due to the following:
4. Other:

Do you have any friends or family members that come to Acuity Orthodontics? If so, please tell us who:

What is most important when it comes to financing the orthodontic treatment?
1. Financing is not important as I will be paying in full to receive the pay in full discount.
2. I want to make a large down payment, so that I can make my monthly payments low.
3. I will need both a low down payment and low monthly payments as finances are a concern.

Does your child have any fear or reservations at dental/doctor visits? If so, please explain:

Is there anything uncomfortable in talking about your child's treatment that you want to list but do not want the Doctor to cover in front of your child during the exam?

If your child is of driving age and will be coming to his/her appointments, we are able to send text and email reminders to both you and your child. We will need the following information to do this:

1. His/Her cell phone number___________________________cell phone carrier________________________
2. His/Her email address____

Thank you for providing the above information so we can provide the best orthodontic care possible. We are honored that you have chosen our office for your orthodontic treatment.