PERSHING ORTHODONTICS

www.pershingortho.com

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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

PLEASE FILL OUT THIS FORM COMPLETELY. The better we communicate, the better we can care for you. EXAMINATION DATE _____ TIME_____

1. TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First M.I.

Nickname: _____ ❑Male ❑Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Home #: _____ Cell #: _____

Child's Home Address: _____
Street

_____
City State Zip

Email: _____

Hobbies/Sports: _____

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? _____

Family members seen in our office: _____

List brothers/sisters with birthday: _____

_____

General Dentist: _____ Last Visit: _____

Parent's Marital Status: ❑ Single ❑ Married ❑ Widowed
❑ Divorced ❑ Separated

3. MOTHER'S INFORMATION — ■ Stepmother ■ Guardian

Name: _____ Birthdate: ___/___/___

Home Ph.: _____ Cell Ph.: _____

Employer: _____ Work Ph.: _____

How Long at Current Job: _____ Job Title: _____

SS#: _____ DL#: _____

FATHER'S INFORMATION — ■ Stepfather ■ Guardian

Name: _____ Birthdate: ___/___/___

Home Ph.: _____ Cell Ph.: _____

Employer: _____ Work Ph.: _____

How Long at Current Job: _____ Job Title: _____

SS#: _____ DL#: _____

4. PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____
Street

_____
City State Zip

Previous Address: _____
Street

_____
City State Zip

Work Ph.: _____ Home Ph.: _____

Employer: _____

SS#: _____ DL#: _____

Nearest Relative/Friend Not Living with You:

Name: _____

Address: _____

Work Ph.: _____ Home Ph.: _____

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: _____

Relationship to Patient: _____

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

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: _____

Relationship to Patient: _____

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

Policy Owner's Employer: _____

6. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

_____

_____

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

If yes, please explain: _____

_____

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

Has menstruation begun? (girls) ..... ❑Yes ❑No

Describe your child's current physical health: ❑Good ❑Fair ❑Poor

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

_____

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

_____

7. HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N	Abnormal Bleeding	Y N	Diabetes
Y N	Allergies to Any Drugs	Y N	Handicap/Disabilities
Y N	Allergic to Latex/Metals	Y N	Hearing Impairment
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	Asthma	Y N	HIV+/AIDS
Y N	Cancer	Y N	Kidney/Liver Problems
Y N	Congenital Heart Defect	Y N	Rheumatic/Scarlet Fever
Y N	Convulsions/Epilepsy	Y N	Tuberculosis (TB)

Please discuss any medical problems your child has had: _____

_____

_____

8. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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 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 during diagnosis and treatment with my informed consent.

_____ _____

Signature of Parent or Guardian Date Signature of Parent or Guardian Date

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

10. THANK YOU FOR FILLING OUT THIS FORM COMPLETELY!

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 or one or more credit reporting companies.

Signature: _____ Date: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

— — — OFFICE USE ONLY — — —

Treatment Coordinator Notes: Intials: _____. Date: _____

_____

_____

_____

_____