PLYMOUTH ORTHODONTICS
BOOKWALTER | FEE | WRIGHT | SHIREY

We welcome you and your child to our office. Please help us prepare for your visit by filling out the following information.

Patient's Name: _____

Prefers to be called: _____ Birth Date: _____ Age: _____

Sex: ☐ Male ☐ Female Gender: _____

Home Address: _____

School: _____ Sports/Hobbies: _____

Siblings: *Name, Age* _____

Other family members who have been seen in our office: _____

How did you hear about us? _____ Referred by: _____

Parent/Guardian

Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Occupation: _____

Parent/Guardian

Name: _____

Address: _____

☐ *Same as other parent* _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Occupation: _____

Marital Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other: _____

Patient living with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Cell phone number you prefer we use for appointment confirmation/communication: _____

Email you prefer we use for appointment confirmation/billing: _____

Primary Dental Insurance

Insured's Name: _____

Employer: _____

Relationship to patient: _____

Insured's DOB: _____

Insured's SSN or ID #: _____

Name of Insurance Company: _____

Group #: _____

Secondary Dental Insurance

Insured's Name: _____

Employer: _____

Relationship to patient: _____

Insured's DOB: _____

Insured's SSN or ID #: _____

Name of Insurance Company: _____

Group #: _____

☐ Check here if no dental insurance

I understand that insurance claims will be submitted by Plymouth Orthodontics' office. I understand that I am responsible for all charges not paid by my insurance. I authorize release of any information relating to this claim to the insurance carrier.

Signature _____ Date _____

Medical History

Primary Care Physician: _____

Date of Last Visit: _____ Phone: _____

Please check any of the following medical conditions for which your child has been treated:

- ☐ Adenoids removed
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ ADD/ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Benign Tumor
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy/Seizures
- ☐ Gastrointestinal Disorders
- ☐ Headache/Migraine
- ☐ Heart condition
- ☐ Head/Facial Injury
- ☐ Hemophilia/Bleeding disorder
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney/Liver Disease
- ☐ Oral Ulcers
- ☐ Previous Surgery
- ☐ Nervous Disorder
- ☐ Radiation/Chemotherapy
- ☐ Speech Problems
- ☐ Thyroid Problems
- ☐ Tonsils Removed
- ☐ Tuberculosis
- ☐ None of these

Other medical or behavioral concerns not listed above that you feel we should be aware of?_____

_____

Is the patient taking any medications? ☐ Yes ☐ No

*Please list medications*_____

Is the patient allergic to any medications? ☐ Yes ☐ No

*Please list medications*_____

Does the patient have any other allergies? ☐ Yes ☐ No

*Please specify*_____

Does the patient require antibiotic pre-medication for dental procedures? ☐ Yes ☐ No

*Please specify*_____

Has the patient reached puberty? *(menstruation, voice changes, facial hair)* ☐ Yes ☐ No

If yes, when? _____

Estimate of patient's height potential: ☐ Below average ☐ Average ☐ Above average

Is the patient adopted? ☐ Yes ☐ No

Dental History

General Dentist: _____

Date of Last Visit: _____ City: _____

Reason for seeking orthodontic consultation?_____

_____

Has the patient had previous orthodontic treatment or an orthodontic consultation? ☐ Yes ☐ No

Date _____ Dr. _____ City, State _____

Has the patient had any teeth extracted? ☐ Yes ☐ No

*Please specify*_____

Has the patient ever been informed of having any missing or extra teeth? ☐ Yes ☐ No

Has the patient had any injuries to teeth, mouth or jaws? ☐ Yes ☐ No

*Please explain*_____

Does the patient grind or clench his/her teeth? ☐ Yes ☐ No

Does the patient's jaw ever click or get sore? ☐ Yes ☐ No

Does the patient have trouble opening wide or to the side? ☐ Yes ☐ No

Does the patient have any speech problems? ☐ Yes ☐ No

*Please explain*_____

Does the patient have any oral habits? *(thumb/finger/lip sucking, tongue thrust, nail biting)* ☐ Yes ☐ No

*Please specify*_____

Any family history of severe orthodontic problems or "jaw surgery"? ☐ ☐

_____ _____

Responsible Party Signature Date