Welcome to our Practice!

PATIENT INFORMATION

Today's Date: _____

Patient's Full Name: _____ Patient's Date of Birth: ____ /____ / _____

Name child goes by (Nickname): _____

Address: _____ City: _____ Zip:_____

Primary Phone: _____ **Email Address:** _____

Age: _____ Sex: ____ M ____ F SSN: _____-_____-_____

School: _____ Grade: _____

Name and ages of other children in family: _____

If patient is a minor, parent or guardian name: _____

Who has legal custody of Patient: _____

Insurance Policy Holder: _____Yes ___No

Whom may we thank for referring you to our office? _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION

Full Name: _____ Date of Birth: ____ /____ / _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Social Security Number: _____-_____-_____ Relationship to patient: _____

PRIMARY INSURANCE INFORMATION

MEDICAID: _____ HEALTHY KIDS: _____

Insured's Full Name: _____ Insured's Birth Date: ____ /____ / _____

Insured SSN: _____-_____-_____

Insurance Co. _____ Member ID/Policy #_____ Group#:_____

Phone: _____

Insured's Employer: _____ Insured's Employer Phone: _____

EMERGENCY INFORMATION

Name of Emergency Contact person: _____ Phone: _____

MEDICAL HISTORY:

Physician: _____ Date of last visit: ____ /____ / _____

Name of Practice: _____ Phone: _____

PLEASE CIRCLE: Yes or No (If Yes, please fill in details.)

Yes No Is your child in good health?

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized or had any major operations?

If Yes, please give reason and date/s: _____

Yes No Were there any problems at birth?

If Yes, please explain: _____

Yes No Is your child taking any medications?

Please give medication name, dose and reason: _____

Yes No Is your child allergic to any medications, foods, or other? _____

Yes No Has your child ever been involved in a serious accident? _____

PLEASE MARK:

if your child has or has been treated for any of the medical conditions/health issues and elaborate below:

__Abnormal Bleeding	__Dizziness	__Mental Delays
__ADD/ADHD	__Endocrine/Growth	__Neuromuscular Disorder
__Adverse Drug Reactions	__Epilepsy	__Nervous Problems
__Anemia	__Eyesight	__Personality/Social
__Arthritis	__Frequent Infections	__Physical Delays
__Asthma/Hay Fever	__GI Disorders	__Pneumonia
__Autism	__Heart Problems	__Recurrent Headaches
__Bleeding/Transfusions	__Hepatitis	__Rheumatic Fever
__Blood Disorder	__Heart Disease	__Prolonged Bleeding
__Bone Disorders	__Heart Murmur	__Radiation/Chemotherapy
__Cancer/Tumor	__HIV/Aids	__Seizures
__Cerebral Palsy	__High Blood Pressure	__Sickle Cell Disease/Trait
__Cleft lip/palate	__Kidney Problems/Disease	__Significant Injuries
__Congenital Heart Defect	__Herpes	__Speech/Hearing
__Diabetes	__Liver Problems	

Details on any checked item:

_____

_____

Are there any other medical conditions not listed that we should be aware of?

_____

_____

DENTAL HISTORY:

Dentist: _____

Date of last visit: _____

Phone: _____Address: _____

Date of last x-rays (if taken): _____

PEDIATRIC DENTAL HISTORY:

PLEASE CIRCLE: Yes or No (If Yes, please fill in details.)

Yes No Has your child experienced any unfavorable reaction from previous dental care?
Yes No Does your child suck a finger, thumb, or pacifier?
Yes No Does your child have pain with chewing, yawning, or opening of his/her mouth?
Yes No Does your child's jaw make noise and is pain associated with the sounds?
Yes No Is your child presently experiencing any dental pain?
Explain: _____
Yes No Has your child ever lost or chipped any teeth?
Yes No Have there been any injuries to your child's mouth or teeth?
Yes No Is any part of your child's mouth sensitive to temperature or pressure?
Yes No Do your child's gums bleed when they brush?
Yes No Does your child have any type of thumb or tongue habit? _____
Yes No Is your child a mouth breather?
Yes No Has your child ever seen an orthodontist?

What concerns you most about your child's teeth?

_____

AUTHORIZATION & RELEASE:

- **I have read and answered the above questions to the best of my knowledge.**
- **I authorize my insurance company to pay Palm Tree Orthodontics all insurance benefits otherwise payable to me for services rendered.**
- **I authorize the use of this signature on all insurance submissions.**
- **I authorize Palm Tree Orthodontics to release all information necessary to secure the payment of benefits.**
- **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature of Parent or Legal Guardian: _____ Date: _____ /_____ / _____

PARENTAL PERMISSION TO CONSENT:

Please provide the names of any persons whom you consent to bring your child to dental appointments. Keep in mind that this person will be able to consent for treatment and will be financially responsible for any payments on that day of service.

_____ _____
_____ _____

PHOTO &VIDEO RELEASE:

I hereby give permission for images of my child captured during any/all Palm Tree Orthodontics visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Palm Tree Orthodontics; promotional material and publications and waive any rights of compensation or ownership thereto.

Name of Patient (Please print): _____ Age: _____
Name of Parent/Guardian (Please Print): _____
Signature of Parent or Legal Guardian: _____ Date: _____ /_____ / _____