Child Information Form

WELCOME
To assist us in providing the most complete service, please provide the following information and health history.

MARC allen DDS MS ORTHODONTICS

Date_____

PERSONAL INFORMATION

Name _____ Nickname _____
First Middle Last

Sex_____Age_____ Date of birth_____School_____Grade_____
MO. DAY YR.

Brothers/Sisters (Name and age) _____

Dentist _____ Physician _____

Referred by _____

Mother **Father**

Name _____ Name_____

Address _____ Address_____
(if different)

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

Home phone_____ Home phone _____

Mobile phone _____ Mobile phone_____

Employed by _____ Employed by _____

Work phone _____ Work phone _____

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

Marital Status _____ Marital Status _____

Parent's email address _____ Parent's email address _____

Person Responsible For Account _____

PRIMARY DENTAL INSURANCE ONLY

Ortho coverage? ☐ Yes ☐ No If "Yes" complete below

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 DENTAL INSURANCE ONLY

Ortho coverage? ☐ Yes ☐ No If "Yes" complete below

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: _____

FOR OFFICE USE ONLY

_____% _____Age _____ WIPE: Y N Waiting: Y N

Insurance Verification Lifetime Max _____ How much Met? _____ Claim Address: _____

Date: _____ _____

Effect Date: _____ How to bill: Mos____ Qtr.____ 6 mos____ Annual____ _____

Ded.: _____ _____

Marc E. Allen, DDS, MS, PA
MEMBER AMERICAN ASSOCIATION OF ORTHODONTISTS
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

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PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Please check box if patient has or has had:

- ❑ Positive HIV test
- ❑ Joint swelling
- ❑ Bone disorders
- ❑ Heart trouble
- ❑ Rheumatic fever
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Emotional problems
- ❑ Brain injury
- ❑ Kidney or liver involvement
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Asthma
- ❑ Epilepsy
- ❑ Prolonged bleeding
- ❑ Faintness/Dizziness
- ❑ Tonsils removed
- ❑ Adenoids removed
- ❑ Sore throats
- ❑ Tonsillitis
- ❑ Earaches

List any other serious illnesses: _____

_____

List any allergies: _____

_____

List drugs or medications now being taken: _____

_____

Is patient under physician's care presently?_____

Reason: _____

Name of physician: _____

Approximately how much has patient grown in the last year? _____

DENTAL HISTORY

Please check box if answer is yes:

- ❑ Any injuries to face, mouth, teeth? (circle)
- ❑ Thumb, finger, lip sucking? (circle)
- ❑ Mouth-breathing when asleep, awake? (circle)
- ❑ More than average amount of decay?
- ❑ Any missing permanent teeth?
- ❑ Any extra permanent teeth?
- ❑ Any teeth removed by extraction?
- ❑ Is there any tongue-thrusting problem?
- ❑ Any speech problems?
- ❑ Any difficulty in swallowing or chewing?
- ❑ Any pain or clicking on opening mouth?
- ❑ Is patient adopted? At what age?_____
- ❑ Does patient visit dentist regularly?

  Date of last dental visit_____
- ❑ Has an orthodontist been consulted previously?

  Reason:_____

List any wind instrument played: _____

_____

Sports: _____

Additional comments: _____

Please note any other factors the doctor should know about the patient's dental health:

_____

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.)

_____

Please describe your reasons for considering orthodontic treatment.

- ❑ Improved facial appearance
- ❑ Improved functional health
- ❑ Enhanced long-term dental health
- ❑ Other_____

Please describe your child's attitude toward orthodontic treatment.

- ❑ Wants it done
- ❑ Does not want it done
- ❑ Does not care

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

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.

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.

X _____

Signature of parent or guardian Date

I authorize the dental staff to perform the necessary dental services my child may need

X _____

Signature of parent or guardian Date

If this office accepts 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.

X _____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.