

Child Information Form



WELCOME

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

Date _____

PERSONAL INFORMATION

Name _____
First Middle Last Nickname _____

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

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes No If "Yes" complete below

Ortho coverage? Yes No If "Yes" complete below

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local, or Policy #): _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

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

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

Policy Owner's Employer: _____

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

Toothmover@Carolina.rr.com
223 Gilead Rd. Huntersville, NC 28078

MARCALLENORTHODONTICS.COM
P:704.875.7999 F:704.875.1998

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Please check box if patient has or has had:

- | | |
|--|--|
| <input type="checkbox"/> Positive HIV test | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> 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? _____

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

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

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: _____

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.