Dr. P. Mike Upton

WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ ❒ Male ❒ Female

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

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: _____

Child's Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

E-mail Address: _____

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? _____

List brothers/sisters w/ Age: _____

_____

General Dentist: _____

Last Visit Date: _____

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

3

Mother's Information: ❒ Step Mother ❒ Guardian

Name: _____

WK#: _____ Ext. _____ HM#: _____

Employer: _____

S.S.# _____ DL#: _____

Father's Information: ❒ Step Father ❒ Guardian

Name: _____

WK#: _____ Ext. _____ HM#: _____

Employer: _____

S.S.# _____ DL#: _____

4 Person Responsible for Account

Name: _____ Relationship: _____

Billing Address: _____

_____
CITY STATE ZIP

WK#: _____ Ext. _____ HM#: _____

Employer: _____

DL#: _____ S.S.# _____

Birthdate: _____ / _____ / _____

Who is responsible for making appointments?

Name: _____

WK#: _____ Ext. _____ HM#: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ____/____/____ & SS#: _____

Insured's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ____/____/____ & SS#: _____

Insured's Employer: _____

CONTINUED ON BACK OF FORM

6 What are the main concerns that you would like orthodontics to accomplish

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ❒ Yes ❒ No

Has there been any injuries to the face, mouth, teeth or chin? ❒ Yes ❒ No

List any musical instruments played _____

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 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

Please 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	Allergic to Plastic	Y	N	Allergic to Latex/Metals
Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis, (TB)	Y	N	Allergies to any Drugs

Please discuss any medical problems that your child has had:

_____

_____

_____

_____

8 Does your child have any of the following habits?

Y	N	Thumb/Finger Sucking	Y	N	Mouth Breather
Y	N	Lip Sucking/Biting	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Nail Biter
Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust

9 AUTHORIZATION

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 this office, use the services of one or more credit reporting services.

_____

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 ADA

10 INSURANCE AUTHORIZATION

I authorize the insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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 guardian Date

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with patient named herein. Initials _____ Date _____

Doctor's Comments:

_____

_____

_____