

FOR CHILDREN: WELCOME TO OUR PRACTICE

LARRY A. ROSE, DDS, MS, INC.

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ABOUT YOUR CHILD		
Today's date: _____		
Child's Name: _____		
_____ Last	_____ First	_____ Mi
Nickname: _____		
DOB: _____ Age: _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female		
School: _____		
Grade: _____		
Home #: _____		
SS#: _____		
Child's hm. add.: _____ Apt#: _____		
City/State/Zip: _____		

RESPONSIBLE PARTY INFORMATION	
Name: _____	
Billing Address: _____	
City/State/Zip: _____	
Work #: _____	Ext. _____
Home #: _____	Cell #: _____
Employer: _____	
SS#: _____	

Who is responsible for making appointments?	
Name: _____	
Work #: _____	Ext. _____
Home #: _____	Cell #: _____

WHO IS THE CHILD WITH TODAY?	
Name: _____	
Relation: _____	
Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Whom may we thank for referring you? _____	

Other family members seen by us: _____	

Previous/Present Dentist: _____	
Street: _____	
Phone #: _____	Last Visit: _____
Parent's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	

PRIMARY DENTAL INSURANCE	
Ins. Name: _____	
Claims Address: _____	

Insurance Co. Phone #: _____	
Group#: _____	
Policy #: _____	
Insured's Name: _____	
Relationship to Patient: _____	
Insured's DOB: _____	
Insured's Employer: _____	
SS#: _____	
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MOTHER'S INFORMATION	
Name: _____	
Address: _____	
Work #: _____	Ext. _____
Home #: _____	Cell #: _____
Employer: _____	
SS#: _____	

FATHER'S INFORMATION	
Name: _____	
Address: _____	
Work #: _____	Ext. _____
Home #: _____	Cell #: _____
Employer: _____	
SS#: _____	

SECONDARY DENTAL INSURANCE	
Ins. Name: _____	
Claims Address: _____	

Insurance Co. Phone #: _____	
Group#: _____	
Policy #: _____	
Insured's Name: _____	
Relationship to Patient: _____	
Insured's DOB: _____	
Insured's Employer: _____	
SS#: _____	
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Why did you bring the child to the Orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Does the child brush teeth daily? Yes No

Floss their teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe child's health: Good Fair Poor

Please list all drugs the child is currently taking:

Please list allergies to drugs or other materials:

Has the child ever had any of the following medical problems?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Prosthesis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Def. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsion/Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheum. Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Any Stays in Hospital |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis (A,B,C?) | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| | <input type="checkbox"/> Y <input type="checkbox"/> N History of Scarlet Fever |

Please discuss any serious problems that the child has had: _____

Does the child have any of the following habits?

- | |
|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Thumb Sucking/Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |

DOCTOR CHECKED MEDICAL HISTORY

I understand the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist 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/Guardian

Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

TO BE FILLED OUT BY THE DOCTOR

LOWER ARCH: _____

UPPER ARCH: _____

CLASS: _____ MIDLINE: _____

OVERJET: _____ OVERBITE: _____

COMMENTS: _____
