

Welcome To Karl Orthodontics

Today's date ___/___/___ Male Female

Child's Name _____
Last First MI

Nickname; _____ SS# _____

Child's Birthdate; ___/___/___ Child's Age; _____

School; _____ Grade; _____

Hobbies/Sports; _____

Child's Home #(____) _____

Child's Home Address; _____

How long have you lived there?: _____

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 with age; _____

General Dentist; _____ Last Visit Date: _____

Parent's Marital Status; Single Widowed Married
 Divorced Separated

Mother's Information Step Mother Guardian

Name; _____ Birthdate; ___/___/___

Wk#(____) _____ Ext; _____ Hm#;(____) _____

Employer; _____ Job Title: _____

How Long at Current Job? _____ SS# _____

DL# _____

Father's Information Step Father Guardian

Name; _____ Birthdate; ___/___/___

Wk#(____) _____ Ext; _____ Hm#;(____) _____

Employer; _____ Job Title: _____

How Long at Current Job? _____ SS# _____

DL# _____

Person Responsible For The Account

Name; _____ Relation; _____

Billing Address; _____

_____ City State Zip

Home #;(____) _____ Wk#(____) _____

Employer; _____

SS# _____ DL# _____

Who Is Responsible for making Appointments?

Name; _____

Wk#;(____) _____ Home#;(____) _____

Neighbor or Relative not living with you?

Name; _____ Phone#;(____) _____

Address; _____

_____ City State Zip

Primary Dental Insurance

Ortho Coverage? Yes No

Insurance Co Name; _____

Insurance Co. Address; _____

Insurance Co. Phone #; _____

Group #; _____

Insured's Name; _____ Relationship; _____

Insured's Birthdate; ___/___/___ SS# _____

Policy #: _____

Insured's Employer; _____

Secondary Dental Insurance

Ortho Coverage? Yes No

Insurance Co Name; _____

Insurance Co. Address; _____

Insurance Co. Phone #; _____

Group#; _____ Employer; _____

Insured's Name; _____ Relationship; _____

Insured's Birthdate; ___/___/___ SS# _____

Policy #: _____

- 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
- Have 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
- Does your child brush his/her teeth daily? [] yes [] no
- Floss his/her teeth daily [] yes [] no
- Is your child currently under the care of a physician? [] yes [] no
- Has menstruation begun? (Girls) [] yes [] no
- Has your child ever taken Phen-Fen? [] yes [] no

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|---|---------------------------------------|
| Y N ABNORMAL BLEEDING | Y N HANDICAPES/DISABILITIES |
| Y N ADD/ADHD | Y N HEARING IMPAIRMENT |
| Y N ALLERGIES TO ANY DRUGS | Y N HEART MURMUR |
| Y N ALLERGIC TO LATEX/METALS | Y N HEMOPHILIA |
| Y N ALLERGIC TO PLASTIC | Y N HEPATITIS |
| Y N ANY HOSPITAL STAYS | Y N HIV+/ AIDS |
| Y N ANY OPERATIONS | Y N KIDNEY PROBLEMS |
| Y N ARTIFICIAL BONES/JOINTS/VALVES | Y N LIVER PROBLESM |
| Y N ASTHMA | Y N LUPUS |
| Y N CANCER | Y N RHEUMATIC/SCARLET FEVER |
| Y N CONGEITAL HEART DEFECT | Y N SICKLE CELL DISEASE/TRAITS |
| Y N CONVULSIONS/EPILEPSY | Y N TUBERCULOSIS (TB) |
| Y N DIABETES | |

Please discuss any medical problems that your child has had:

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services my child may need. This office also reserves the right to verify credit status of potential 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/guardian Date

 Signature of Orthodontist Date