Williams ORTHODONTICS
Your smile is our specialty

Child

Welcome To Our Office!

Please complete the following to help us better care for you

Name: _____ Child prefers to be called: _____

Gender: _____ Date of Birth: _____ Age: _____

Patient's Cell Phone _____ Patient's E-mail: _____
(for appointment reminders)

Dentist: _____ When was their last general dental exam?: _____

Whom may we thank for referring you to our office? _____

With whom does the patient live? ☐ Both parents ☐ Mother ☐ Father ☐ Split Custody

Who should be contacted for appointments and scheduling? ☐ Mother ☐ Father

Preferred Location: ☐ Evergreen ☐ Conifer

Father's Name: _____ Mother's Name _____

Street: _____ Street: _____

City: _____ Zip: _____ City: _____ Zip: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

E-Mail: _____ E-Mail: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

What is your preferred method of communication?
☐ Cell ☐ Home ☐ Text ☐ E-mail

What is your preferred method of communication?
☐ Cell ☐ Home ☐ Text ☐ E-mail

Financially Responsibly Party: _____ Relationship to patient: _____

Is there an insurance company we can contact for you concerning orthodontic coverage? ☐ Yes ☐ No

Insurance Company Name: _____ State: _____
(if applicable)

Policy Holder's Name: _____ Relationship to patient: _____

SS#: _____ Date of birth: _____

Is there a secondary insurance company which may provide coverage? ☐ Yes ☐ No

Insurance Company Name: _____ State: _____
(if applicable)

Policy Holder's Name: _____ Relationship to patient: _____

SS#: _____ Date of birth: _____

Have any family members received treatment in our office? ☐ Yes ☐ No

Are there any other family members that would benefit from an orthodontic consultation? ☐ Yes ☐ No

Please list the first name and date of birth of dependents in your family:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Parent Signature: _____ **Date:** _____

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Medical and Dental History Information

Patient name: _____

Please check any of the following the patient presently has or has had:

- ☐ Sleep apnea
- ☐ Heart condition requiring antibiotic premed
- ☐ High blood pressure
- ☐ Artificial joint
- ☐ Blood or bleeding disorder
- ☐ Anemia
- ☐ Growth disorder
- ☐ Bone disorder
- ☐ Thyroid disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Asthma
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ ADHD
- ☐ Autism
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Cold sores
- ☐ Allergies to latex
- ☐ Allergies to plastics
- ☐ Allergies to metals

Is the patient allergic to any drugs or medications? If so, please list: _____

Does the patient have any other disease or condition worth mentioning? If so, please list: _____

Please describe the patient's current health: ☐ Good ☐ Fair ☐ Poor

Are you aware of any of the following?

- ☐ Popping or clicking in the jaw joint
- ☐ Clenching or grinding
- ☐ Difficulty opening widely
- ☐ Pain in the jaw joint
- ☐ Sore or tired jaw muscles
- ☐ "Tension" headaches
- ☐ Migraine headaches
- ☐ Snoring
- ☐ Tongue thrust

If you answer yes to any of the following, please explain.

Has the patient had any periodontal or gum problems? ☐ Yes ☐ No _____

Is the patient having any pain or discomfort? ☐ Yes ☐ No _____

Have there been any injuries to the patient's teeth or mouth? ☐ Yes ☐ No _____

Have you been informed of missing or extra permanent teeth? ☐ Yes ☐ No _____

Does/did the patient ever suck a thumb, finger, or lip? ☐ Yes ☐ No _____

Does the patient frequently breathe through their mouth and have an open mouth posture? ☐ Yes ☐ No _____

Has the patient had their tonsils or adenoids removed? ☐ Yes ☐ No _____

Have the patient ever been treated by an orthodontist or seen an orthodontist for a consultation? ☐ Yes ☐ No _____

What is the patient's attitude toward braces? ☐ Eager ☐ Willing ☐ Indifferent ☐ Resigned ☐ Opposed

Does the patient: follow directions well? ☐ Yes ☐ No brush their teeth well? ☐ Yes ☐ No

Is the patient self-conscience about their teeth? ☐ Yes ☐ No _____

Please list concerns about the patient's teeth or smile: _____

What concerns you about orthodontic treatment? (check all that apply)

- ☐ Appearance of appliances
- ☐ Discomfort
- ☐ Results
- ☐ Cost
- ☐ Length of treatment time
- ☐ Fitting appointments into your schedule

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes in health/medication.

Parent Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____