Cabezon ORTHODONTISTS

The benefit of a happy, healthy smile is immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely and to the best of your knowledge

ABOUT YOUR CHILD

Name: _____
I prefer to be called: _____ Male/Female
Date of Birth: _____Age:_____

Home Address: _____

_____
City State Zip
Home#_____ Parents Cell#_____
Email address_____
School: _____ Grade: _____
Is the patient adopted? Yes No
Mother's Name: _____
Address: _____

_____
City State Zip
Phone: _____
Occupation: _____
Employer: _____
Father's Name: _____
Address: _____

_____
City State Zip
Phone: _____
Occupation: _____
Employer: _____
Parents are: (circle one)
Married Separated Divorced Widowed Other
Stepparent's Name: _____
Phone: _____
Stepparent's Name: _____
Phone: _____
Name of Person(s) who might accompany your child to their appointments: _____

_____
Names & Ages of other children in your family: _____

_____
Who may we thank for referring you to our office: ____

_____

INSURANCE

Do you have Dental coverage? _____
Insurance Co. Name: _____
Insurance Co. Phone#: _____
Group #: _____
Policyholder: _____
Date of Birth:_____
Social Security # _____
Employer: _____
Second Insurance Co. Name: _____
Second Policyholder: _____
Group #: _____
Date of Birth: _____
Social Security#: _____

Insurance

Insurance is filed as a courtesy to you.
It is the responsibility of the policy holder to know the policy limits and maximums. Insurance is not a guarantee of payment if insurance fails to pay its estimated portion I understand that I will be responsible for the remaining balance.
_____initials

Assignment and Release

I, the undersigned, certify that I or my dependent have insurance coverage and assign directly to Cabezon Orthodontists. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I hereby authorize Cabezon Orthodontists to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party signature
Relationship_____

Date:_____

Please complete this section when the responsible party for the account is <u>not</u> listed on this form.
Person responsible for account_____
Home#_____ Work#_____
Relationship: _____
Billing Address: _____

_____
City state Zip

Medical History

Do you have a physician? Yes No

Physician's Name: _____

Address: _____

Phone: _____Date of last visit _____

Your current health is excellent good fair poor

Are you currently under the care of a physician? Yes No

If yes please explain: _____

Do you smoke or use tobacco of any form? Yes No

Have you had any metal Pins, Rods, Implants or Joint replacements? Yes No

Are you taking ANY medications? Yes No

Please list each one:

_____

_____

Have you had any of the following medical problems or diseases?

__ Alcohol/Drug abuse
__ Anemia
__ Anxiety
__ Artificial bones/joints/valves
__ Asthma
__Blood/bleeding Disorder
__Bone disorder
__ Cancer /Chemotherapy
__ Colitis
__ Diabetes
__ Difficulty Breathing
__Emphysema
__ Epilepsy/seizures
__Endocrine problems
__ Fainting Spells
__ Frequent Headaches
__ Glaucoma
__ Heart problems
__ Heart Murmur
__ Hepatitis
__ Herpes/Fever Blisters
__ High Blood Pressure
__Immune disorder
__Kidney Problems
__Liver Disease
__Low blood Pressure
__ Osteoporosis/osteopenia
__ Pneumonia
__ Psychiatric Problems
__ Radiation Treatment
__ Rheumatic/Scarlet Fever
__ Shingles
__ Sickle cell disease/trait
__ Sinus Problems
__ Sleep Apnea
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers

Please list any serious medical conditions that you have ever had:

_____

Have your_____ tonsils or _____adenoids been removed?

If yes, at what age? _____

Please circle if you are allergic to any of the following?

Aspirin Erythromycin Penicillin
Codeine Metals Tetracycline
Dental Anesthetics Latex Other

Please list any other drugs/materials you are allergic to:

_____

_____

For Adolescents: Has the patient reached puberty? Yes No

Height: _____ Weight: _____

Females: Has menstruation started? Yes No If yes, what age? _____

Males: Has his voice changed? Yes No If yes, what age? _____

Dental History

Do you have regular Dentist? Yes No

Dentist Name: _____

Specialist?: _____

When did the patient last receive dental care: _____

Routine or Emergency (circle one)

Their current dental health is good fair poor

How frequently do you brush your teeth? _____

Use dental floss? _____

Do they take antibiotics before dental treatment? Yes No

Are they currently in pain? Yes No

Do they have any jaw, joint or facial pain? Yes No

Have their teeth or either of their jaws been injured? Yes No

If yes, how old were they? _____ If yes, what was the cause of the accident? _____ Which teeth and/or jaw were involved? _____

Have they ever had an unfavorable dental experience? Yes No

Does the child like her/his smile? Yes No

Are their teeth sensitive to heat, cold, or anything else? _____

Have you been informed that the patient has any missing or extra permanent teeth? _____

Does the patient have, or have they ever had any of the following habits?

__ Constant mouth breathing
__ Grinding teeth
__Gum Chewing
__ Ice Chewing
__ Lip biting
__ Lip sucking
__ Nail biting
__ Thumb or Finger sucking
__ Tongue thrusting
__ Other_____

Does the patient have a speech problem?

_____

Describe the patient's orthodontic problem as you it?

_____

Does anyone in your family have a similar dental or facial condition?

_____

Has anyone else in your family received orthodontic care?

_____

Has an orthodontist been consulted previously?

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature_____

Date_____

****It is the responsibility of the policy holder to know the policy limits and maximums. ****