

Welcome

Today's Date _____ 20____

Your Child

Child's Name _____ Birthdate _____ Age _____
Nickname _____ Sex _____ Race _____
Mailing Address _____ City _____ ST _____ Zip _____
Home Phone _____ SS# _____
School _____ Grade _____ Hobbies _____
Whom may we thank for your referral: _____

Mother __Stepmother__ Guardian
Name _____
Address _____
Home Phone _____ Cell _____
Email _____
Employer _____
Occupation _____
SS# _____

Father __Stepfather__ Guardian
Name _____
Address _____
Home Phone _____ Cell _____
Email _____
Employer _____
Occupation _____
SS# _____

Date of birth _____
Marital Status _____

Date of Birth _____
Marital Status _____

Medical History

Is the patient in good health?..... Yes No
Does the patient have any history of major illness?..... Yes No
Have tonsils and adenoids been removed?..... Yes No
List any drugs and medications being taken. Give Reasons. _____

List any drug allergies or drug sensitivity _____
Height _____ Weight _____

Check any of the following for which the patient has been treated:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Involvement | |
| <input type="checkbox"/> Frequent Headaches | | <input type="checkbox"/> Nervous Disorders | |

Dental History

Patient's Dentist _____ Last Dental Exam _____

Have there been injuries to the face, mouth, or teeth?-----Yes No

Does the patient have any speech problems?-----Yes No

Is the patient a mouth breather? While awake?-----Yes No

While sleeping?-----Yes No

Have you been informed of any missing or extra permanent teeth?-----Yes No

Has an orthodontist been consulted previously? -----Yes No

I consent to the taking of photographs and X-rays before, during and after treatment. I authorize the use of any photographs and X-rays for the purpose of teaching and scientific publications. I have received a copy of informed consent and understand the risks and limitations in orthodontic treatment. I do hereby consent to payment in full for services rendered. I also confirm that I have received a copy of this office's Notice of Privacy Practices.

Signature of Parent or Guardian

Date

If you have Orthodontic Insurance please fill out the following:

Patient's Name: _____

Insured's Name: _____

Relationship: _____

Insured's Birthdate: _____ / _____ / _____

Insured SS#: _____ - _____ - _____

Employer: _____

Employer Address: _____

Insurance Company Name: _____

Insurance Company Address: _____

Group #: _____

I hereby authorize the release of any information necessary in the processing of claims and understand that I am responsible for all costs of orthodontic treatment.

Signature

Date

I hereby authorize payment directly to Dr. Ste. Marie of orthodontic benefits otherwise payable to me.

Signature

Date