STORIE & STURGILL ORTHODONTICS

CHILD

About Your Child

Name:_____
Last First MI

Nickname:_____ ☐ Male ☐ Female

Birthdate:____/____/_____Age:_____SS#: _____

Home Address:_____

_____
City State Zip

School: _____Grade: _____

Hobbies/sports:_____

Musical Instruments:_____

General Information

Who is accompanying the child today?

Name:_____

Relation: _____ Legal Guardian? ☐ Yes ☐ No

Who is financially responsible for the account?

_____

Who is responsible for making appointments?

_____

Parent's Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Child's Medical History

Physician's Name: _____

Phone#: (_____)_____ Last Visit: _____

Child's physical health is: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____

Child currently being treated by a physician? ☐ Yes ☐ No

If yes, please explain: _____

Has puberty begun? ☐ Yes ☐ No ☐ Unsure

Has your child ever had any metal rods, pins, or implants? ☐ Yes ☐ No

Please list any prescriptions or over-the-counter drugs your child takes:

_____

_____

Has your child ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? ☐ Yes ☐ No

Are your child's immunizations current? ☐ Yes ☐ No

Anything would like to discuss with the Doctor in private? ☐ Yes ☐ No

Females Only:

Has she begun menstruation? ☐ Yes ☐ No

Does she take birth control? ☐ Yes ☐ No

Is she pregnant? ☐ Yes ☐ No

Parent's Information

☐ **Father** ☐ Step Father ☐ Guardian ☐ Other _____

Name: _____
Last First MI

Birthdate:____/____/_____ SS#:_____

Address (if different): _____

_____
City State Zip

Cell #:(_____)_____ Wk#: (_____)_____

Email: _____

Preferred contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Employer: _____

How long there? _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Orthodontic Insurance Benefit? ☐ Yes ☐ No ☐Unsure

Insured's name (if different): _____

Insurance Co. Name: _____

Insurance Co Phone #: (_____)_____

Group # (Policy/Plan #): _____

Parent's Information

☐ **Mother** ☐ Step Mother ☐ Guardian ☐ Other _____

Name: _____
Last First MI

Birthdate:____/____/_____ SS#:_____

Address (if different): _____

_____
City State Zip

Cell #:(_____)_____ Wk#: (_____)_____

Email: _____

Preferred contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Employer: _____

How long there? _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

Orthodontic Insurance Benefit? ☐ Yes ☐ No ☐Unsure

Insured's name (if different): _____

Insurance Co. Name: _____

Insurance Co Phone #: (_____)_____

Group # (Policy/Plan #): _____

Child's Allergies

Does your child have any allergies? ☐ Yes ☐ No If Yes, please **circle** from the list below or write in the space provided:

Aspirin Metals/Nickel Advil/NSAIDs Penicillin Latex Codeine

Other allergies and reaction: _____

Has your child ever had any of the following? (circle)

Y N ADD/ADHD	Y N Emphysema	Y N Hemophilia/Blood Disorder	Y N Prosthetic
Y N Autism Spectrum/Asperger's	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems
Y N AIDS/HIV	Y N Fainting Spells	Y N Herpes/Fever Blisters	Y N Rheumatic/Scarlet Fever
Y N Artificial Joints/Valves	Y N Frequent Headaches	Y N Hospital Stay/Operations	Y N Seizures/Convulsions
Y N Asthma	Y N Handicap/Disability	Y N High Blood Pressure	Y N Sickle Cell Disease/Trait
Y N Cancer	Y N Hay Fever	Y N Liver Disease	Y N Sinus Problems
Y N Colitis	Y N Hearing Impairment	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N Heart Surgery	Y N Lupus	Y N Tuberculosis (TB)
Y N Diabetes	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Ulcers

Other medical condition(s): _____

_____

Child's Dental History

List concerns you have about your child's smile and/or bite:

_____

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Does your child have any of the following habits? (Circle)

Y N Lip Sucking/Biting Y N Nail Biting Y N Tongue Thrust Y N Thumb/Finger Sucking

General/Pediatric Dentist: _____

Last Visit: _____ Reason for Visit: _____

Has your child ever been seen by an orthodontist?	☐Yes ☐ No	Does your child grind or clench your teeth?	☐ Yes ☐ No
Does your child have any missing permanent teeth?	☐Yes ☐ No	Has your child ever been treated for TMJ/TMD?	☐ Yes ☐ No
Does your child brush his/her daily?	☐Yes ☐ No	Does your child have pain in his/her jaw joints?	☐ Yes ☐ No
Family history of jaw surgery to correct his/her bite?	☐Yes ☐ No	Does your child's jaw routinely pop or click?	☐ Yes ☐ No
History of facial birth defects or cleft palate?	☐ Yes ☐ No	Has your child's jaw ever locked closed or open?	☐ Yes ☐ No
Has your child ever had speech problems?	☐ Yes ☐ No	Does your child experience pain in his/her ears?	☐ Yes ☐ No
Does your child commonly snore?	☐ Yes ☐ No	Have adenoids and/or tonsils been removed?	☐ Yes ☐ No
History of major trauma/injury of the face, jaw, teeth, or mouth?	☐ Yes ☐ No	Does your child most commonly breathe through his/her (circle one)	Mouth Nose

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Storie & Sturgill Orthodontics. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including records of examination, diagnosis, and treatment rendered, to my insurance company.

I understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment, with my informed consent. I understand that Storie & Sturgill Orthodontics reserves the right to verify the credit status of patients and/or their parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, the ADA, and the AAO.

_____

Signature Date

OFFICE USE ONLY

I have verbally reviewed the medical/dental information with the patient named herein.

TC Signature/Date: _____ Doctor Signature: _____