Argyle Orthodontics

Patient Name_____ ❑Male ❑Female

Social Security #_____ Birth Date _____ Age _____

Home Address_____

City _____ State_____ Zip_____

Primary Phone # _____ ❑home ❑cell Ok to leave Message? ❑Y ❑N

Email _____

School _____ Grade_____

List any sports or extracurricular activities _____

Siblings (names and ages) _____

Parent's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Significant Other

❑ Mother ❑ Step-Mother ❑Guardian ❑Other Name_____

Social Security #_____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State_____ Zip_____

Phone # _____ ❑home ❑cell Secondary Phone #_____ ❑home ❑cell

Employer's Name _____ Occupation_____

❑ Father ❑ Step-Father ❑Guardian ❑Other Name_____

Social Security #_____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State_____ Zip_____

Phone # _____ ❑home ❑cell Secondary Phone #_____ ❑home ❑cell

Employer's Name _____ Occupation_____

Emergency Contact Name (other than parent) _____

Phone # _____ Relation to child _____

Address_____

City _____ State_____ Zip_____

Person(s) OK to release appointment or medically related information to concerning child.

_____ Relation(s) _____

Primary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

General Dentist _____ Last Visit _____

How did you hear about our Practice? ❑Ad ❑Internet ❑ Family or Friend ❑Physician ❑Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

_____

Have your child visited an orthodontist before? ❑Y ❑N

When? _____ Reason? _____

Have we treated any other family members? ❑Y ❑N Name _____

Have your child's tonsils or adenoids been removed? ❑Y ❑N

Has your child ever experienced jaw joint pain/ discomfort (TMJ/TMD) ? ❑Y ❑N

Does your child have any missing or extra permanent teeth? ❑Y ❑N

Has your child ever had an injury to (*select all that apply*) : ❑Teeth ❑Mouth ❑Chin

Does your child have speech problems? ❑Y ❑N If so, explain _____

Does your child currently or has your child ever had any of the following habits (*check all that apply*)

❑Clenching/Grinding Teeth ❑Mouth Breathing ❑Thumb/ Finger Sucking

❑Lip Sucking/Biting ❑Nail biting ❑Chewing/Eating Problem

Is your child currently being treated by a physician? ❑Y ❑N Reason _____

Physician _____ Last Visit _____ Phone _____

Does your child have any allergies/sensitivities to medications or latex? ❑Y ❑N If yes, please list.

_____

Is your child currently taking any prescription or over-the-counter medications? ❑Y ❑N

Please list, with dosage. _____

Has puberty and/or menstruation begun? ❑Y ❑N ❑N/A

- 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 the office of any changes in my child's medical status.
- I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party Date