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JENNINGS ORTHODONTICS

inspiring smiles

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Tell Us About Your Child

Today's Date ______ /______ /______ Nickname ______________________

Child's Name ____
LAST FIRST MI

Child's Birthdate _____/_____/_____ Child's Age _______ ☐ M ☐ F

Child's E-mail Address ____________________________________

School ______________________________ Grade: __________

Hobbies/sports: ____________________________________

Child's Hm #: (_______) ____________________________

Child's Home Address ____________________________________

____
CITY STATE ZIP

General Information

Who is accompanying the child today?

Name: ______________________________ Relation: ______________

Do you have legal custody of this child? ☐ Y ☐ N

Whom may we thank for referring you? ______________________

Other siblings/ages: ______________________________

____

General Dentist: ______________________________

Dentist Ph: (_______) ______________ Last Visit Date: ____________

Parent's Information

Who is responsible for account? ______________________ Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Stepfather ☐ Guardian

Name: ______________________________ Birthdate: ____ /____ /____

Address: (If different than Child's) Hm #: (_______) ______________

____

____

Wk : (_______) ______________ Cell #: (_______) ______________

Email: ____

Employer: ______________________ Occupation: ______________

Employer Address: ______________________________________

____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: ____________________________________

Insurance Address: ____________________________________

____
CITY STATE ZIP

Ins. Ph : (_______) ____________________________________

Insured's ID # or Social Security #: ______________________

Group # (Plan, Local or Policy #): ________________________

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: ______________________________ Birthdate: ____ /____ /____

Address: (If different than Child's) Hm #: (_______) ______________

____

____

Wk #: (_______) ______________ Cell#: (_______) ______________

Email: ____

Employer: ______________________ Occupation: ______________

Employer Address: ______________________________________

____

If you have orthodontic insurance coverage for the child, please fill out below:
CITY STATE ZIP

Insurance Co. Name: ____________________________________

Insurance Address: ____________________________________

____
CITY STATE ZIP

Ins. Ph : (_______) ____________________________________

Insured's ID # or Social Security #: ______________________

Group # (Plan, Local or Policy #): ________________________

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, 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 the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ ______________
SIGNATURE OF PARENT OR GUARDIAN DATE

CONTINUED ON BACK

Dental and Medical History

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

____

____

Has you child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

Does the child require antibiotics before dental treatment? ☐ Y ☐ N

Have adenoids or tonsils been removed? ☐ Y ☐ N

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

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Y ☐ N

Does the child brush teeth daily? ☐ Y ☐ N Floss daily? ☐ Y ☐ N

Child's Physician: ____

Ph #: (_______)____________________ Date of last visit:______________

Is the child currently under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

GIRLS: Has menstruation begun? ☐ Y ☐ N

Indicate the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

____________________ ____________________

____________________ ____________________

Does your child have allergies to any of the following?

Latex ☐ Y ☐ N Nickel/Metals ☐ Y ☐ N Plastic ☐ Y ☐ N

Please list any other allergies that the child may have:

____________________ ____________________

____________________ ____________________

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hemophilia
Y	N	Any Hospital Stays/Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Problems
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Prosthetics
Y	N	Convulsions	Y	N	Rheumatic Fever
Y	N	Diabetes	Y	N	Scarlet Fever
Y	N	Epilepsy	Y	N	Sickle Cell Disease/Traits
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Y ☐ N

Would you like to discuss anything with the Doctor in private? ☐ Y ☐ N

Please list any serious medical problems the child has had:

____

____

____

Does/did the child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Speech Problems
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Pacifier Usage

List any musical instruments played: ______________________

____

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

ORTHODONTIC INFORMATION RELEASE PER **HIPAA**

Patient Name: ____ Date of Birth: _____/_____/_____

I authorize the release of information including diagnosis, records, claims and financial information. This information may be released to:

______________________________, ______________________________,

______________________________ & ______________________________.

☐ I do not authorize the release of information to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: ____ Date: _____/_____/_____

OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

____

SIGNATURE OF DOCTOR DATE

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: ______________________________

____

Has there been any changes in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: ______________________________

____

____

PARENT/GUARDIAN SIGNATURE DATE

____

DOCTOR SIGNATURE DATE

____

PARENT/GUARDIAN SIGNATURE DATE

____

DOCTOR SIGNATURE DATE