

New Patient Information

Montgomery & Prattville Pediatric Dentistry and Orthodontics, P.C.

Date _____

Patient's Name _____ Goes by _____ Date of Birth _____ Age _____ Sex _____

Address _____

Home Phone _____ School _____ Grade _____ Child's SSN _____

Responsible Party Information

Parent's Marital Status (circle one): Married Widowed Divorced Separated Single

Mother's Name _____ Father's Name _____

Date of Birth _____ SS# _____ Date of Birth _____ SS# _____

Drivers License# _____ State _____ Drivers License# _____ State _____

Employer _____ Employer _____

Occupation _____ No. Years Employed _____ Occupation _____ No. Years Employed _____

Business Telephone _____ Ext _____ Business Telephone _____ Ext _____

Cell # _____ E-mail _____ Cell # _____ E-mail _____

Insurance Information

Subscriber's Name _____ SS# _____ Date of Birth _____

Insurance Company _____ Contract Number _____ Group Number _____

Do you have dual coverage? If YES, complete the following:

Subscriber's Name _____ SS# _____ Date of Birth _____

Insurance Company _____ Contract Number _____ Group Number _____

General Appraisal

What concerns you most about your child's teeth? _____

Has any member of your family had orthodontic treatment? _____

On a scale of 1-10, how motivated is the patient to start orthodontic treatment? _____

Whom may we thank for referring you to our office? _____

How did you hear about our office? _____

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Medical History

Check any boxes that apply to the patient:

- Currently under physician's care? Describe: _____
 - Currently taking medications? Describe: _____
 - Any allergies to medication? Describe: _____
 - Any contact allergies (latex, nickel, etc.)? Describe: _____
 - Has patient reached puberty? Girls-Has she started Menstruation? _____ Boys-Has voice changed? _____
- | | | |
|--|--|---|
| <input type="checkbox"/> Congenital heart problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tonsils & Adenoids removed |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Smoke/Chew tobacco |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Currently pregnant |

Please describe any medical conditions checked above: _____

Has your physician recommended pre-medication with antibiotics for routine dental visits? () Yes () No

Does patient have any medical problems not listed above? Is yes, please describe: _____

Dental History

Dentist: _____ Date of last cleaning: _____

How often does patient brush? _____ Floss? _____

List any musical instruments played: _____

Check any boxes that apply to the patient:

- Has patient ever sucked a thumb or finger? Until what age: _____
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Injury to face, mouth, or teeth | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Gum Disease |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Extra teeth | <input type="checkbox"/> Grinding/Clenching |

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by Montgomery Pediatric Dentistry & Orthodontics to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical/dental status, I will inform the office of Montgomery Pediatric Dentistry & Orthodontics. I agree to be financially responsible for any and all charges for services rendered by this office. I further understand I am responsible for any collection agency and/or attorney fees, if those services are required to collect for any services provided by this office.

I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____ Reviewed By: _____