



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-size: 2em; color: red; border: 1px solid red; border-radius: 50%; padding: 2px 5px;">1</span> <span style="font-weight: bold; font-size: 1.2em;">Tell Us About Your Child</span> </div> <p>Today's Date: _____ Nickname: _____</p> <p><b>Child's Name:</b> _____  <small style="margin-left: 100px;">LAST</small> <small style="margin-left: 100px;">FIRST</small> <small style="margin-left: 100px;">MI</small></p> <p>E-mail Address: _____</p> <p>Birthdate: ____ / ____ / ____ Age: ____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>School: _____ Grade: _____</p> <p>Hobbies/Sports: _____</p> <p>Child's Home #: (____) _____</p> <p><b>Child's Home Address:</b> _____  <small style="margin-left: 250px;">APT/CONDO#</small></p> <p>CITY _____ STATE _____ ZIP _____</p> </div>	<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-size: 2em; color: red; border: 1px solid red; border-radius: 50%; padding: 2px 5px;">4</span> <span style="font-weight: bold; font-size: 1.2em;">Person Responsible For Account</span> </div> <p>Name: _____ Relation: _____</p> <p>Billing Address: _____  <small style="margin-left: 100px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>Email Address: _____</p> <p>Hm# (____) _____</p> <p>Employer: _____</p> <p>Wk# (____) _____ Ext: _____ SS#: _____</p> <p style="text-align: center;"><b>Who is responsible for making appointments?</b></p> <p>Name: _____</p> <p>Wk# (____) _____ Ext: _____ HM#: _____</p> <p>Email Address: _____</p> </div>
<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-size: 2em; color: red; border: 1px solid red; border-radius: 50%; padding: 2px 5px;">2</span> <span style="font-weight: bold; font-size: 1.2em;">Who is Accompanying Your Child Today?</span> </div> <p>Name: _____ Relation: _____</p> <p>Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Who referred you to us?</i> _____</p> <p>List brothers / sisters with age: _____</p> <hr/> <p><i>General Dentist:</i> _____</p> <p><i>Address/City:</i> _____</p> <p>Last Visit Date: _____</p> <p>Parent's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced  <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> </div>	<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-size: 2em; color: red; border: 1px solid red; border-radius: 50%; padding: 2px 5px;">5</span> <span style="font-weight: bold; font-size: 1.2em;">Primary Orthodontic Insurance</span> </div> <p>Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance Co. Name: _____</p> <p>Insurance Co. Address: _____</p> <p>Insurance Co. Phone #: (____) _____</p> <p>Group # (Plan, Local, or Policy #): _____</p> <p><b>Policy Owner's Name:</b> _____</p> <p>Relationship to Patient: _____</p> <p><b>Policy Owner's Birthdate:</b> ____ / ____ / ____ <b>ID #:</b> _____</p> <p><b>Policy Owner's Employer:</b> _____</p> <p>Employer's Address: _____</p> </div>
<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-size: 2em; color: red; border: 1px solid red; border-radius: 50%; padding: 2px 5px;">3</span> <span style="font-weight: bold; font-size: 1.2em;">Mother's Information</span> </div> <p><input type="checkbox"/> <b>Mother's Information</b> <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian</p> <p>Name: _____ Birthdate: ____ / ____ / ____</p> <p>Wk#: (____) _____ Ext: _____ Hm#: (____) _____</p> <p>Employer: _____</p> <p>How Long at Current Job: _____ Job Title: _____</p> <p>SS #: _____</p> <hr/> <p><input type="checkbox"/> <b>Father's Information:</b> <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian</p> <p>Name: _____ Birthdate: ____ / ____ / ____</p> <p>Employer: _____</p> <p>How Long at Current Job: _____ Job Title: _____</p> <p>SS#: _____</p> </div>	<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="font-weight: bold; font-size: 1.2em;">Secondary Orthodontic Insurance</span> </div> <p>Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance Co. Name: _____</p> <p>Insurance Co. Address: _____</p> <p>Insurance Co. Phone #: (____) _____</p> <p>Group # (Plan, Local, or Policy #): _____</p> <p><b>Policy Owner's Name:</b> _____</p> <p>Relationship to Patient: _____</p> <p><b>Policy Owner's Birthdate:</b> ____ / ____ / ____ <b>ID#:</b> _____</p> <p><b>Policy Owner's Employer:</b> _____</p> <p>Employer's Address: _____</p> <p style="text-align: center;">City _____ State _____ Zip _____</p> </div>

**6** What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has your child ever been evaluated or had orthodontic treatment before?  Yes  No

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

List any musical instruments played: \_\_\_\_\_

Have adenoids or tonsils been removed?:  Yes  No

Has your child been informed of any missing or extra permanent teeth?  Yes  No

**Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?**  Yes  No

Does your child brush his / her teeth daily?  Yes  No

Floss his / her teeth daily?  Yes  No

Child's Physician: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Is your child currently under the care of a physician?  Yes  No

Has puberty begun?  Yes  No

Has menstruation begun? (Girls)  Yes  No

**Please describe your child's current physical health:**

Good  Fair  Poor

Please list all medications that your child is currently taking: \_\_\_\_\_

Please list all medications / things that your child is allergic to: \_\_\_\_\_

Y N Latex      Y N Metals/Nickel      Y N Plastics

Other: \_\_\_\_\_

**7** Has your child ever had any of the Following medical problems?

- |                                        |                             |
|----------------------------------------|-----------------------------|
| Y N Abnormal Bleeding                  | Y N Convulsions/Epilepsy    |
| Y N ADD / ADHD                         | Y N Diabetes                |
| Y N Allergies to any Drugs             | Y N Handicaps/Disabilities  |
| Y N Allergic to Latex/Metals           | Y N Hearing Impairment      |
| Y N Allergic to Plastic                | Y N Heart Murmur            |
| Y N Any Hospital Stays                 | Y N Hemophilia              |
| Y N Any Operations                     | Y N Hepatitis               |
| Y N Artificial Bones / Joints / Valves | Y N HIV+ / AIDS             |
| Y N Asthma                             | Y N Kidney/Liver Problems   |
| Y N Cancer                             | Y N Lupus                   |
| Y N Congenital Heart Defect            | Y N Rheumatic/Scarlet Fever |
|                                        | Y N Tuberculosis (TB)       |

Please list any medical problems that your child has had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8** Has your child ever experienced any of the following?

- |                              |                           |
|------------------------------|---------------------------|
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking/Biting       | Y N Speech Problems       |
| Y N Mouth Breather           | Y N Thumb/Finger Sucking  |
| Y N Nail Biting              | Y N Tongue Thrust         |

Neighbor or Relative not living with you.

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

- 9**
- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
  - Our Privacy Policy is on our website: [www.drdougbrown.com](http://www.drdougbrown.com)
  - The Parent or Guardian who accompanies the child is responsible for payment. The Patient is responsible for payment. **If necessary, I hereby authorize Douglas M. Brown, DDS, MS, Inc. to obtain a copy of my credit report from a credit-reporting agency for the purpose of considering payment options. Credit history is used to evaluate financing for orthodontic treatment and will not be retained, reports will be destroyed following credit evaluation.**

NOTE: *Obtaining an Equifax credit report does not alter the responsible party's credit score in any way.*

\_\_\_\_\_  
 Signature of parent or guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

**We are HIPAA Compliant and committed to meeting or exceeding infection control standards of OSHA, CDC and the ADA**

**OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY**

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

**Doctor's Comments:**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_