# Welcome to Fischer Family Orthodontics

Today's Date_____ Nickname_____

Child's Name_____

Date of Birth _____/_____/_____ Age _____ ◯ Male ◯ Female ◯ Unspecified

Address_____
Street City State Zip Code

Hobbies/Sports/Musical Instruments_____

Whom may we thank for referring you?_____

General Dentist_____ Last Visit Date_____

Who is responsible for Account?_____

Other family members seen by us_____
Parent's Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Widowed ◯ Divorced ◯ Separated

**Parent/Guardian** ◯ Father ◯ Mother ◯ Step Father ◯ Step Mother ◯ Guardian
Name_____ Date of Birth_____
Address (if different from Child's)_____
Cell #_____Employer_____
Occupation_____

**Parent/Guardian** ◯ Father ◯ Mother ◯ Step Father ◯ Step Mother ◯ Guardian
Name_____ Date of Birth_____
Address (if different from Child's)_____
Cell #_____Employer_____
Occupation_____

Dental Insurance Carrier_____
Telephone #_____ Subscriber ID #_____

**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.**

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 insurances 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

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 |
| Does the child require antibiotics before dental treatment? | ◯ Yes | ◯ No |
| Have adenoids or tonsils been removed? | ◯ Yes | ◯ No |
| Does your child have any missing or extra permanent teeth? | ◯ Yes | ◯ No |
| **Has the child ever had any pain/tenderness in his/her jaw (TMJ/TMD)?** | ◯ Yes | ◯ No |
| Does the child brush his/her teeth daily? | ◯ Yes | ◯ No |
| Floss his/her teeth daily? | ◯ Yes | ◯ No |

Child's Physician_____

Phone #_____Date of Last Visit_____

| | | | |
|---|---|---|---|
| Is the child currently under the care of a physician? | | ◯ Yes | ◯ No |
| Has puberty begun? | | ◯ Yes | ◯ No |
| Has menstruation begun? | | ◯ Yes | ◯ No |
| **Please describe the child's current physical health:** | ◯ **Good** | ◯ **Fair** | ◯ **Poor** |

**Please list all drugs that the child is currently taking:_____**

**Aside from the items listed below, list all drugs/things your child is allergic to:_____**

| | | | | | |
|---|---|---|---|---|---|
| **Y / N** | **Latex** | **Y / N** | **Nickel/Metals** | **Y / N** | **Plastic** |

**Has the child experienced the following medical problems?**

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

| | | |
|---|---|---|
| Are the child's immunizations current? | ◯ Yes | ◯ No |
| **Anything you would like to discuss with the Doctor in private?** | ◯ **Yes** | ◯ **No** |

Please discuss any serious medical problems the child has had_____

Does/did the child experience any of the following:

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

I understand that the information I have given is correct to the best of my knowledge, that it 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 the necessary dental/orthodontic services my child may need.

_____

Signature of Parent or Guardian Date

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I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments_____