CHAD JOHNSON ORTHODONTICS

CHILD WELCOME FORM

(Please Print)

Today's date:			
CHILD INFORMATION			
Child's last name:	First:	Middle:	
Nickname:			
Birth date: / /	Age:	Sex: ❑ M ❑ F	Email:
Home address:			Home #:
City:	State:	ZIP:	SSN #:
School:	Grade:	Hobbies/Sports:	
GENERAL INFORMATION			
Whom may we thank for referring you?			
General Dentist:	Last Visit Date:		
Dentist Phone #:			
Other Siblings:			

PARENT'S INFORMATION			
Who is responsible for the account:	Parent's Marital Status: ❑Single ❑Married ❑Partnered ❑Widowed ❑Divorced ❑Separated		
❑ Father ❑Step Father ❑Guardian		❑ Mother ❑Step Mother ❑Guardian	
Name:	Birth date: / /	Name:	Birth date: / /
Address:		Address:	
City:	State: ZIP:	City:	State: ZIP:
SSN:	Cell #:	SSN:	Cell #:
Work #:	Home #:	Work #:	Home #:
Email:		Email:	
Employer:	Occupation:	Employer:	Occupation:
Employer's Address:		Employer's Address:	
City:	State: ZIP:	City:	State: ZIP:
If you have Orthodontic Insurance Coverage for the Child, please fill out below:		*If you have Orthodontic Insurance Coverage for the Child, please fill out below:*	
Insurance Company Name:		Insurance Company Name:	
Insurance Address:		Insurance Address:	
City:	State: ZIP:	City:	State:
Insurance Phone #:		Insurance Phone #:	
Group #:	ID #:	Group #:	ID #:

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 the office, use the services of credit reporting agencies. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance company does not cover. I authorize the dentist to release all information necessary to secure the payment of benefits. 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:*

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Child's Physician's Name:

Phone #:

Your child's current physical health is: ❑ Good ❑Fair ❑Poor

Is your child currently under the care of a physician? ❑ Yes ❑ No
Please explain:

Are your child's immunizations current? ❑ Yes ❑ No

Is your child currently taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one:

Has your child ever had any of the following diseases or medical problems:

Y	N	Abnormal bleeding/Hemophilia	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS	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/Chemotherapy	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)

List any serious medical condition(s) that your child has ever had:

_____

_____

_____

_____

Is your child allergic to any of the following?

Y N Latex Y N Nickel/Metals Y N Plastic

List any other drugs/materials that your child is allergic to: _____

_____

DENTAL HISTORY

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

_____

Has your child ever been evaluated for orthodontic treatment? ❑ Yes ❑ No

Has your child ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Has your child ever experienced pain or discomfort in their jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your child's current dental health is: ❑ Good ❑ Fair ❑ Poor

Has your child ever had injury to your (circle one): Mouth Teeth Chin

Does your child have any speech problems? ❑ Yes ❑ No

Does your child generally breathe through their mouth? ❑ Yes ❑ No

If yes, please circle: While Awake While Asleep

Does your child have any missing or extra permanent teeth? ❑ Yes ❑ No

Does your child require antibiotics before dental treatment? ❑ Yes ❑ No

Does your child brush their teeth daily? ❑ Yes ❑ No

Does your child floss their teeth daily? ❑ Yes ❑ No

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

Y	N	Clenching/Grinding Teeth	Y	N	Lip Sucking/Biting
Y	N	Nail Biting	Y	N	Thumb/Finger Sucker
Y	N	Tongue Thrust	Y	N	Used Pacifier

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

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: _____ *Date:* _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have read the Notice of privacy practices for the above named practice.

Signature _____ *Date:* _____