KEYSER Orthodontics
Live Life Smiling

Welcome

We would like to welcome you and your child to our office. In an effort to provide the best care, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Child or Teen

Patients Name_____ Age _____ Birth Date_____
First Middle Last

Nickname (if preferred) _____ Male / Female Patient's Home Phone _____

Who is filling out this form? _____ Relationship_____
First Last

Do you have legal custody of the patient? Yes No How did you hear about our office?_____

Patient's General Dentist _____ Has your child visited an orthodontist before? Yes No

Have we treated another member of your family? Yes No If Yes, Name _____
First Last

What are the main concerns that you have with the patients smile/bite? _____

Parents/Guardian Information

Father

Father Stepfather Guardian Name _____
First Middle Last

Martial Status: Single Married Widowed Divorced Separated Domestic Partner Birth Date _____

Address_____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer _____ Social Security Number _____

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

Insurance Company Name _____ Insurance Phone Number _____

Insurance Company Address _____

Plan/ Group ID # _____ Member ID # _____

Mother

Mother Stepmother Guardian Name _____
First Middle Last

Martial Status: Single Married Widowed Divorced Separated Domestic Partner Birth Date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer _____ Social Security Number _____

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

Insurance Company Name _____ Insurance Phone Number _____

Insurance Company Address _____

Plan/ Group ID # _____ Member ID # _____

Dental and Medical History

Is the child currently under the care of a physician for a medical reason? Yes No What reason _____

Child's Physician _____ Phone _____

History of major illness? Yes No If Yes, please describe _____

Any sensitivities or allergies? Yes No If Yes, please list_____

Currently taking any medications? Yes No If Yes, please list_____

Has the child been treated for: Blood Disorder Diabetes Heart Condition Tuberculosis Epilepsy Cancer Nervous Disorder

Does the child require antibiotics before dental treatment? Yes No If Yes, please explain _____

Has the child had adenoids and/or tonsils removed? Yes No

Has the child or any family member have/had any extra or missing permanent teeth? Yes No

Has the child had any injuries to their face, mouth or chin? Yes No

Has the child ever had any pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

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

Grinding teeth Finger/Thumb sucking Prolonged bottle or pacifier Mouth breather Speech problems Chewing/eating problems

Authorization and Signature

I understand that the information that I have provided 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 to my child's medical or insurance status.

I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor, radiographs for treatment purposes and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____