WELCOME TO CAPPS ORTHODONTICS

CHILD PATIENT INFORMATION:

Name:___________________________________ Prefer to be called:______________________ Sex:_____

Home Address:_____________________________________ City:______________ State:_____ Zip:______

Patient resides with: ☐ Mother ☐ Father ☐Both ☐Other: __________________

Responsible Party Primary Phone: ______________ Age: _____ Birth date: _______________

Responsible Party E-mail:_____________________________________

Patient's Dentist: ___________________________________ School: ________________Grade:__________

Describe your child's orthodontic problem:____

Patient's interests:____

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

Parents and Account Information

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

	FATHER	MOTHER
Name:	____________________	____________________
Address (if different than above)	____________________	____________________
Phone (if different than above)	____________________	____________________
Social Security Number:	____________________	____________________
Employer's Name:	____________________	____________________
Business Address:	____________________	____________________
Business Phone:	____________________	____________________
Occupation:	____________________	____________________
How long with this employer:	____________________	____________________
Person responsible for account:	____________________	____________________

If other than parent:
Name: _____________________Address: _______________________________Phone: _________
In case of an emergency, please provide name, address and phone number of your nearest relative:
Name: _____________________Address:_______________________________ Phone: _________

DENTAL INSURANCE INFORMATION
If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):____

Date of Birth: _________________ Social Security#__________-__________-___________

Name of insurance company:________________________ Group #: _________ ID#: __________

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name: ____________________________ Address: ________________________ Phone: _________
Has your child experienced any health problems? ☐ No ☐ Yes Explain: ________________________________
Any major change in your child's health recently? ☐ No ☐ Yes Explain: ________________________________
Is your child currently under a physician's care? ☐ No ☐ Yes Explain: ________________________________
Is your child currently taking any medications? ☐ No ☐ Yes Explain: ________________________________
Is your child allergic to any medications? ☐ No ☐ Yes Explain: ________________________________
Has your child received a blood transfusion? ☐ No ☐ Yes Explain: ________________________________
Have your child's tonsils or adenoids been removed? ☐ No ☐ Yes Explain: ______________________________

Please check if your child has had any of the following conditions:

Heart Murmur……..……☐ No ☐ Yes	Hepatitis……..…..☐ No ☐ Yes	Emotional Problems…. ☐ No ☐ Yes
Heart Surgery……..……..☐ No ☐ Yes	Diabetes……..…..☐ No ☐ Yes	Frequent Headaches…. ☐ No ☐ Yes
Rheumatic Fever……..…☐ No ☐ Yes	Kidney Disease…☐ No ☐ Yes	Nervous/Anxious…..…. ☐ No ☐ Yes
Endocrine disorders……☐ No ☐ Yes	Liver Disease...….☐ No ☐ Yes	Cancer……………..…. ☐ No ☐ Yes
Prolonged Bleeding……☐ No ☐ Yes	Tuberculosis…….☐ No ☐ Yes	Bone Disorders………. ☐ No ☐ Yes
Anemia……..…………☐ No ☐ Yes	Bronchitis……….☐ No ☐ Yes	Growth Disorders……. ☐ No ☐ Yes
Blood Disease…………☐ No ☐ Yes	Asthma………….☐ No ☐ Yes	Mouth Breather…..…. ☐ No ☐ Yes
Developmental Disorder.☐ No ☐ Yes	Epilepsy...……….☐ No ☐ Yes	Herpes (Fever Blisters). ☐ No ☐ Yes
Hives/Rash…..…………☐ No ☐ Yes	Fainting...……….☐ No ☐ Yes	Tonsillitis…………..…. ☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? __________________________________

Growth Information for Patients Under 16 Years of Age:

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in selection of treatment alternatives.

Has your son or daughter reached puberty? ☐ No ☐ Yes
Girls- Has she started menstruation? ☐ No ☐ Yes When? ___________________________
Boys- Has his voice changed? ☐ No ☐ Yes When? ___________________________
Father's Height__________ Mother's Height________ Adopted ☐ No ☐ Yes
Names and Birthdates of patient's brothers and sisters: ____
Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes With Whom? ____________________________

Dentist's Name: ____________________ Address: ____________________________________ Phone: _____________
Dental checkups: ☐2 times a year ☐1 time a year ☐Only if problem exists ☐Never Date of Last Visit:_______________
Is there any unfinished care to be completed with your child's dentist? ☐ No ☐ Yes Explain: ____________________
Is your child frightened about dental treatment? ☐ No ☐ Yes Explain: ____________________
Has your child had an unpleasant experience in the dental office? ☐ No ☐ Yes Explain: ____________________
Has your child had any facial or dental injuries? ☐ No ☐ Yes Explain: ____________________
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Explain: ____________________
Does your child play any musical instruments? ☐ No ☐ Yes Explain: ____________________
Has your child consulted an orthodontist previously? ☐ No ☐ Yes Explain: ____________________
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain: ____________________
Has your child had any previous orthodontic treatment? ☐ No ☐ Yes Explain: ____________________
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: ____________________
Any changes in your child's bite or dental alignment recently? ☐ No ☐ Yes Explain: ____________________

Please check if there is a history of:
☐ Clenching teeth ☐ Muscular Soreness around head & neck ☐Jaw joint soreness ☐Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐Jaw joint clicking ☐Ringing in the ears
☐ Speech problems (if so what sounds _______________) ☐Mouthbreathing Awake_______ Asleep_______
Is there any other information which may be helpful? ____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future.

____ ____

Parent Signature **Date** **Reviewed by**