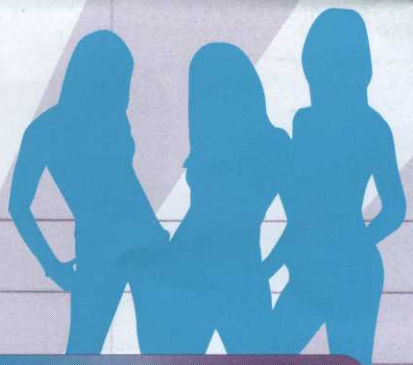
Welcome



1 About Your Teen

Today's Date: ____/____/____ File #: _____

Teen's Name: _____
LAST FIRST M.I.

Teen's Nickname: _____ ❑ Boy ❑ Girl

Teen's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Teen's Home Phone #:(____) _____

Teen's SS#: _____

Teen's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 Teen's Family Information

Who is accompanying this teen today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO TEEN

Do you have Legal Custody of this Teen? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS TEEN'S)** HOME ADDRESS CITY STATE ZIP

(____)_____ (____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS TEEN'S)** HOME ADDRESS CITY STATE ZIP

(____)_____ (____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO TEEN

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(____)_____ _____ (____)_____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

_____ /_____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

5 Teen's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Teen in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s): _____

Does teen require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day teen brushes? _____ Times a week teen flosses? _____

Is the teen's water fluoridated? ❑ Yes ❑ No

How would you rate the teen's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Teen's Medical History

Is Teen taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others: _____

Teen's Physician: _____ (____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam: ____/____/____
ADDRESS CITY STATE ZIP

Does Teen have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** Chicken Pox
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia/Abnormal Bleeding	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** High/Low Blood Pressure	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) teen has or ever had: _____

_____

Is Teen allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s): _____

Please rate the teen's general health from 1-10: _____ Does teen wear contact lenses? ❑Yes ❑No

Has this teen ever taken the drug Ritalin? ❑ No ❑ Yes/How long? _____ Teen's Blood type: _____

Does this teen do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments