



**Stephen Tanner, D.D.S.**  
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Family Orthodontics

**W**e would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1 Tell Us About Your Child

Date: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Child's Full Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Child's home phone: (\_\_\_\_) \_\_\_\_\_  
 Child's home address: \_\_\_\_\_ # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Who is accompanying your child today? \_\_\_\_\_  
 Is your child adopted?  Yes  No  
 Do you have legal custody of this child?  Yes  No  
 Parent's marital status:  
 Single  Married  Divorced  Separated  Widowed  
 List brothers/sisters with ages: \_\_\_\_\_  
 \_\_\_\_\_  
 Whom may we thank for referring your child? \_\_\_\_\_  
 \_\_\_\_\_

## 2 Mother's Information

- Stepmother  
 Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Work #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Home #: (\_\_\_\_) \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 How long at current job? \_\_\_\_\_ Job title: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_

## Father's Information

- Stepfather  
 Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Work #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Home #: (\_\_\_\_) \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 How long at current job? \_\_\_\_\_ Job title: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_

## Person Responsible for Account

Who is responsible for the financial arrangements?  
 Name: \_\_\_\_\_

## 3 Neighbor/Relative Not Living With You

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## 4 Orthodontic Insurance

### PRIMARY

Orthodontic coverage?  Yes  No Dental coverage?  Yes  No  
 Insurance Co. name: \_\_\_\_\_  
 Insurance Co. address: \_\_\_\_\_  
 Insurance Co. phone: (\_\_\_\_) \_\_\_\_\_  
 Group # (plan, local or policy #) \_\_\_\_\_  
 Insured's name: \_\_\_\_\_  
 Insured's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_  
 Insured's SS #: \_\_\_\_\_  
 Insured's employer: \_\_\_\_\_

### — FOR OFFICE USE ONLY —

Date ins. checked: \_\_\_\_\_ Effec. date: \_\_\_\_\_  
 Life max: \_\_\_\_\_ % \_\_\_\_\_  
 Age limit: \_\_\_\_\_ Any used? \_\_\_\_\_  
 Deduct: \_\_\_\_\_ Wait period? \_\_\_\_\_  
 Non-dup. clause: \_\_\_\_\_  
 Updates: \_\_\_\_\_

### SECONDARY

Orthodontic coverage?  Yes  No Dental coverage?  Yes  No  
 Insurance Co. name: \_\_\_\_\_  
 Insurance Co. address: \_\_\_\_\_  
 Insurance Co. phone: (\_\_\_\_) \_\_\_\_\_  
 Group # (plan, local or policy #) \_\_\_\_\_  
 Insured's name: \_\_\_\_\_  
 Insured's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_  
 Insured's SS #: \_\_\_\_\_  
 Insured's employer: \_\_\_\_\_

### — FOR OFFICE USE ONLY —

Date ins. checked: \_\_\_\_\_ Effec. date: \_\_\_\_\_  
 Life max: \_\_\_\_\_ % \_\_\_\_\_  
 Age limit: \_\_\_\_\_ Any used? \_\_\_\_\_  
 Deduct: \_\_\_\_\_ Wait period? \_\_\_\_\_  
 Non-dup. clause: \_\_\_\_\_  
 Updates: \_\_\_\_\_

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## Medical History

Child's physician: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is your child currently under the care of a physician? ....  Yes  No

Please describe your child's current physical health:

Good  Fair  Poor

Has puberty begun? .....  Yes  No

If your child is female, has menstruation begun? .....  Yes  No

Please list all drugs that your child is currently taking: \_\_\_\_\_

Please list all drugs/things that your child is allergic to: \_\_\_\_\_

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

Abnormal bleeding.....  Y  N Fever blisters/Herpes .....  Y  N

ADD/ADHD .....  Y  N Handicaps/Disabilities .....  Y  N

Any drug allergies .....  Y  N Hearing impairment.....  Y  N

Allergy to latex/metal .....  Y  N Heart murmur .....  Y  N

Allergy to plastics.....  Y  N Hemophilia .....  Y  N

Any hospital stays.....  Y  N Hepatitis .....  Y  N

Any operations.....  Y  N HIV+/AIDS .....  Y  N

Artificial bones/joints.....  Y  N Kidney/Liver problems.....  Y  N

Artificial valves .....  Y  N Mitral valve prolapse .....  Y  N

Asthma.....  Y  N Rheumatic fever .....  Y  N

Cancer .....  Y  N Scarlet fever .....  Y  N

Congenital heart defect ....  Y  N Sinus problems.....  Y  N

Convulsions/Epilepsy.....  Y  N Tonsil/Adenoid condition....  Y  N

Diabetes.....  Y  N Tuberculosis (TB).....  Y  N

Please elaborate on any medical problems that your child has had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Dental History

General Dentist: \_\_\_\_\_

Last visit date: \_\_\_\_\_

What are the main concerns that you would like orthodontic treatment 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

List any musical instruments played:.....

Have adenoids or tonsils been removed? .....  Yes  No

Has your child been informed of any missing or extra permanent teeth? .....  Yes  No

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? .....  Yes  No

Does your child brush/floss his/her teeth daily?.....  Yes  No

Does your child require antibiotic coverage prior to dental procedures?.....  Yes  No

Has your child ever had any of the following problems?

Clenching/grinding teeth....  Y  N Nursing bottle habits .....  Y  N

Lip sucking/biting .....  Y  N Speech problems .....  Y  N

Mouth breather.....  Y  N Thumb/finger sucking.....  Y  N

Nail biting .....  Y  N Tongue thrust.....  Y  N

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## Consent

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize insurance payments to my attending orthodontists. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDA and the ADA, as well as adhering to the privacy policies set forth by the HIPAA Act of 1996.**

— FOR OFFICE USE ONLY — — FOR OFFICE USE ONLY — — FOR OFFICE USE ONLY —

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Orthodontist's or Treatment Coordinator's comments: \_\_\_\_\_

\_\_\_\_\_  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Update: \_\_\_\_\_

\_\_\_\_\_  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Update: \_\_\_\_\_

\_\_\_\_\_  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_