DOPAZO ORTHODONTICS

Please complete this form and bring it to your new patient appointment.

**WE LOOK FORWARD TO YOUR VISIT!**

## PATIENT INFORMATION

| | | |
|---|---|---|
| **Name of Minor/Child:** | Preferred Name: | Today's Date: |
| SEX: ☐ Male ☐ Female | | Date of Birth: |
| School and Grade: | | Age: |
| Home Address:<br>City/State/ZIP | | Home Phone:<br>E-Mail: |
| Employer: | | Work Phone: |
| Hobbies: | | |
| Whom may we thank for referring you: | | General Dentist: |

## FAMILY INFORMATION

| | | | |
|---|---|---|---|
| **Father's name:** | | **Mother's Name:** | |
| **DOB:** | **S.S. #** | **DOB:** | **S.S #** |
| Home Address:<br>(*if different from patient*) | | Home Address:<br>(*if different from patient*) | |
| Employer: | | Employer: | |
| Work Phone: | | Work Phone: | |
| E-mail: | | E-mail: | |
| Please list other family members treated here: | | | |

## DENTAL/ALLERGY HISTORY

| | |
|---|---|
| Date of patient last dental visit: | Purpose of last visit: |
| What are the main concerns that you would like orthodontics to accomplish? | |
| Has your child been evaluated for orthodontics treatment before? | ☐ Yes ☐No |
| Has your Child had any injuries to the face, mouth or chin? | ☐ Yes ☐No |
| Has your Child been informed of any missing or extra permanent teeth? | ☐ Yes ☐No |
| Has your Child had any pain/tenderness in his/her jaw joint (TMJ/TMD)? | ☐ Yes ☐No |
| Does your child brush his/her teeth daily? | ☐ Yes ☐No |
| Does your child floss his/her teeth daily? | ☐ Yes ☐No |
| Does your child play any musical instruments that involve the mouth? | ☐ Yes ☐No |

| | | | | |
|---|---|---|---|---|
| Has your child had any of these dental related problems: | Clenching/Grinding Teeth | ☐ Yes ☐No | Mouth Breather | ☐ Yes ☐No |
| | Lip Sucking/Biting | ☐ Yes ☐No | Nail Biting | ☐ Yes ☐No |
| | Speech Problems | ☐ Yes ☐No | Tongue Thrust | ☐ Yes ☐No |
| | Thumb/Finger sucking | ☐ Yes ☐No | | |

| | | | |
|---|---|---|---|
| **Allergies:** Does your child have any of these allergies? | **Aspirin** ☐Yes ☐No | **Codeine** ☐Yes ☐No | **Dental Anesthetics** ☐Yes ☐No |
| | **Latex** ☐Yes ☐No | **Metal** ☐Yes ☐No | **Erythromycin** ☐Yes ☐No |
| | **Penicillin** ☐Yes ☐No | | **Tetracycline** ☐Yes ☐No |
| | Other Allergies: | | |

**Handicaps/Disabilities:**

**More IMPORTANT details need to be completed on the back of this form. Thank you!**

**For Office Use ONLY**

**Patient I.D.#**

## MEDICAL HISTORY

| | | |
|---|---|---|
| Child's Physician: | Phone Number: | Date of Last Visit: |
| Emergency Contact: | Phone Number: | Relationship: |

Medical Conditions:

Does your child have or has he/she had any of these medical conditions?

| | | | |
|---|---|---|---|
| Abnormal Bleeding | □Yes □No | Heart Disease | □Yes □No |
| ADD/ADHD | □Yes □No | Heart Murmur | □Yes □No |
| Anemia/Radiation Treatment | □Yes □No | Hemophilia | □Yes □No |
| Artificial Bone/Joint/Valves | □Yes □No | Hepatitis (□A □B □C) | □Yes □No |
| Arthritis | □Yes □No | High/Low Blood pressure | □Yes □No |
| Asthma | □Yes □No | Kidney/Liver Problems | □Yes □No |
| Cancer/Leukemia | □Yes □No | Measles/Mumps | □Yes □No |
| Cerebral Palsy | □Yes □No | Mitral Valve Prolapse | □Yes □No |
| Congenital Heart Defects | □Yes □No | Mononucleosis | □Yes □No |
| Diabetes | □Yes □No | Pregnant (currently) | □Yes □No |
| Drug/Alcohol Abuse | □Yes □No | Psychiatric Problems | □Yes □No |
| Fever Blisters | □Yes □No | Rheumatic/Scarlet Fever | □Yes □No |
| Hearing Impairment | □Yes □No | Thyroid Disease | □Yes □No |
| Heart Attack/Problems | □Yes □No | Tuberculosis (TB) | □Yes □No |

**Please list any current medications being used by your child and the reason for each:**

## RESPONSIBLE PARTY INFORMATION

| | |
|---|---|
| Person Financially Responsible: | Date of Birth: |
| Relationship to Patient | Social Security Number: |
| Home Address:<br>*(if Different from patient)* | Home Phone:<br>Work Phone: |
| Employer: | E-Mail: |

## RESPONSIBLE PARTY INSURANCE INFORMATATION

| | |
|---|---|
| Do you have orthodontic coverage for this minor? □Yes □No | Employer: |
| Relationship to Patient: | Insured's Name: |
| Insurance Company: | Insured's Date of Birth: |
| Insurance Claims Address: | Ins. I.D. # |
| | Ins. Group # |
| Insurance Company Phone: | Social Security # (required): |

**Financial Information Signature Requirement**

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and/or deductibles that my insurance does not cover.

Signature of Patient/Responsible Party Date

This office reserves the right to verify credit of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Patient/Responsible Party Date

**Treatment Authorization Signature Requirement**

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 it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform and necessary dental services I may need during diagnostic and treatment.

Signature of Patient/Responsible Party Date

**For Office use ONLY**

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

Doctor's Comments:

Doctor's Initial: Date: