Welcome!

To Your Orthodontist!

Scott Stein, D.D.S. ● 20 North Main Street ● Pittsford, NY 14534

Tell Us About Your Child

Today's Date: _____

Child's Name: _____ (Last / First / MI) Nickname: _____ Home Phone: _____

Child's Birthdate: ____/____/____ Age: _____ Gender at Birth: _____ Identifies as: _____

Child's Home Address: _____ (Street / City / State / Zip) Parent's Email Address: _____

School: _____ Grade: ____ Extracurricular Activities: _____

Who is accompanying the child today? _____ Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No Other Siblings: _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

General Dentist: _____ Phone: _____ Last Visit Date: ___/___/____

Whom may we thank for referring you? _____

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Partnered

PARENT: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian Home Phone: _____ Cell Phone: _____

Name: _____ Birthdate: ____/____/_____ Social Security #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____ Work Phone: _____

Employer's Address: _____ (Street / City / State / Zip)

If you have Orthodontic Insurance Coverage for the Child, please fill out: **Insurance Co. Name:** _____

Phone: (____)_____ **Group # (Plan, Local, or Policy #):** _____ **ID #:** _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

PARENT: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian Home Phone: _____ Cell Phone: _____

Name: _____ Birthdate: ____/____/_____ Social Security #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____ Work Phone: _____

Employer's Address: _____ (Street / City / State / Zip)

If you have Orthodontic Insurance Coverage for the Child, please fill out: **Insurance Co. Name:** _____

Phone: (____)_____ **Group # (Plan, Local, or Policy #):** _____ **ID #:** _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

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Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

Has your child ever been evaluated for ortho treatment? ☐ **Yes** ☐ **No** Has your child ever had orthodontic treatment? ☐ **Yes** ☐ **No**

Have adenoids or tonsils been removed? ☐ **Yes** ☐ **No** Have there been any injuries to the face, mouth, teeth or chin? (please circle)

Does the child require antibiotics before dental treatment? ☐ **Yes** ☐ **No** Does your child have any missing/extra permanent teeth? ☐ **Yes** ☐ **No**

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

Does the child brush his / her teeth daily? ☐ **Yes** ☐ **No** Floss his / her teeth daily? ☐ **Yes** ☐ **No**

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

☐ Lip Sucking/Biting	☐ Clenching/Grinding Teeth	☐ Tongue/Cheek Biting	☐ Mouth Breather
☐ Nail Biting	☐ Thumb/Finger Sucking	☐ Speech Problems	☐ Tongue Thrust
☐ Chewing on Objects			

List any musical instruments played: _____

Medical History

Child's Physician: _____ Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Has puberty begun? ☐ Yes ☐ No Has menstruation begun? ☐ Yes ☐ No **Height: Child's:** ____ **Father's:** ____ **Mom's:** ____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all drugs that the child is currently taking: _____

Aside from items listed below, please list all drugs and/or things that cause the child allergic reactions:

Latex? ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No Tetracycline? ☐ Yes ☐ No

_____

_____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Abnormal Bleeding	☐ Cancer	☐ Heart Murmur	☐ Mitral Valve Prolapse
☐ ADD/ADHD	☐ Chicken Pox	☐ Hemophilia	☐ Mononucleosis
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Convulsions	☐ Hives	☐ Scarlet Fever
☐ Any Hospital Stay / Operations	☐ Diabetes	☐ Kidney Problems	☐ Sickle Cell Anemia
☐ Artificial Bones/Joints/Valves	☐ Epilepsy	☐ Liver Problems	☐ Skin Rash
☐ Asthma	☐ Handicaps/Disabilities	☐ Lupus	☐ Tonsillitis
☐ Blood Transfusion	☐ Hearing Impairment	☐ Measles	☐ Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. We can not extend credit without the social security number of the responsible party.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent or Guardian Date

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

_____

Dentist's Signature Date

Dentist's Comments: _____

_____