kids care DENTAL & ORTHODONTICS™

Orthodontic New Patient Information

PATIENT INFORMATION			
Patient Name (Last, First, M.I.):		Nickname:	
Social Security #:		Birth Date:	☐ M ☐ F
Name of School:		Grade:	# of Siblings:
Primary Orthodontic Concerns:			

LEGAL GUARDIAN #1/PRIMARY CONTACT			
Name of Primary Contact (Last, First, M.I.):			
Relationship to Patient:	☐ M ☐ F	Birth Date:	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated			
Social Security #:	Driver's License #:		State of Issuance:
Email:	Mobile #:		Work #:
Street Address:			
City:		State:	Zip:

LEGAL GUARDIAN #2/SECONDARY CONTACT (IF APPLICABLE)			
Name of Secondary Contact (Last, First, M.I.):			
Relationship to Patient:	☐ M ☐ F	*Birth Date:*	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated			
Social Security #:	Driver's License #:		State of Issuance:
Email:	Mobile #:		Work #:
Street Address:			
City:		State:	Zip:

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

☐ Mail/Print ☐ Event ☐ Online Ad ☐ Social Media (ex. Facebook)

☐ Drive-by/Walk-in ☐ Google/Search ☐ Email ☐ Other

☐ Radio/TV ☐ Insurance Directory ☐ Review Website (ex. Yelp)

☐ Referred by a Kids Care Dental patient? If so, please list their name:

☐ Referred by a Kids Care Dental dentist? If so, please list their name:

☐ Referred by a pediatrician or other dentist? If so, please list their name:

kids care DENTAL & ORTHODONTICS™

FAMILY INFORMATION	
Name(s) of Children:	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:

INSURANCE INFORMATION (PRIMARY & SECONDARY)			
Name of Primary Insured (Last, First, M.I.):			
Patient's Relationship to Primary Insured:	Insured's Birth Date:		☐ M ☐ F
Insured's Street Address:			
City:	State:	Zip:	
Employer Name:	SSN #:		
Primary Insurance Name:	ID #:	Group #:	
Primary Insurance Street Address:			
City:	State:	Zip:	
Name of Secondary Insured (Last, First, M.I.):			
Patient's Relationship to Secondary Insured:	Insured's Birth Date:		☐ M ☐ F
Insured's Street Address:			
City:	State:	Zip:	
Employer Name:	SSN #:		
Secondary Insurance Name:	ID #:	Group #:	
Secondary Insurance Street Address:			
City:	State:	Zip:	

HEALTH INFORMATION

Has the patient ever had any of the following? Please check all that apply:

☐ Abnormal Bleeding	☐ Autism	☐ Hepatitis	☐ Rheumatic Fever
☐ ADD/ADHD	☐ Cancer/Tumor	☐ High Blood Pressure	☐ Scarlet Fever
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Irregular Heartbeat	☐ Seizures/Convulsions
☐ Anemia	☐ Diabetes	☐ Kidney Problems	☐ Sickle Cell Disease/Trait
☐ Artificial Joints/Valves	☐ Epilepsy	☐ Liver Problems	☐ Sinus Problems
☐ Asthma	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis (TB)

Has the patient ever experienced any of the following? Please check all that apply:

☐ Clenching/Grinding Teeth	☐ Mouth Breather	☐ Speech Problems	☐ Tongue Thrust
☐ Lip Sucking/Biting	☐ Nail Biting	☐ Thumb/Finger Sucking	☐ Used Pacifier

Additional Questions:

Has the patient ever been evaluated for orthodontic treatment before?	☐ Yes	☐ No
Have there been any injuries to the face, mouth, teeth or chin?	☐ Yes	☐ No
Does the patient require antibiotics before dental treatment?	☐ Yes	☐ No
We use disclosing tablets and solutions to reveal harmful bacterial plaque on teeth. These disclosing products DO contain food dyes. Do you or your child have any food dye allergies?	☐ Yes	☐ No
Have adenoids or tonsils been removed?	☐ Yes	☐ No
Does the patient have any missing or extra permanent teeth?	☐ Yes	☐ No
Has the patient ever had any pain/tenderness in his/her jaw join (TMJ/TMD)?	☐ Yes	☐ No
Does the patient brush and floss his/her teeth daily?	☐ Yes	☐ No
Has the patient ever been prescribed Fosamax or any other bisphosphonate?	☐ Yes	☐ No
Are the patient's immunizations current?	☐ Yes	☐ No
Has the patient been admitted to the hospital or needed emergency care during the past two years?	☐ Yes	☐ No
Does the patient have any health problems that need further clarification?	☐ Yes	☐ No

If yes, please explain:

Please list all drugs that the patient is currently taking:

Please list all allergies the patient has:

Name of General Dentist:	Date of Last Visit:
Name of Physician:	Date of Last Visit:

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical status.

Signature (patient or guardian (if under 18)):	Date:
Signature of Orthodontist:	Date:

HIPAA NOTICE OF PRIVACY PRACTICES	
Signature below is acknowledgement that you have received and understand the HIPPA Notice of Privacy Practices.	
Signature:	**Date:**

PERMISSION TO TAKE ORTHODONTIC RECORDS	
In order to best diagnose orthodontic treatment, there are three initial records we need to take. These records include intraoral photographs (taken with a digital camera), a panoramic x-ray that shows all the teeth in the mouth on one film, and a cephalometric x-ray that shows a side profile so the doctor can evaluate the patient's jaw position. These records will be taken at no charge during your consultation appointment. For the patient's safety, we use low-radiation x-ray technology and will only take these radiographs if we do not have recent images on file. No photographs or x-rays will be used for any reason other than diagnostic purposes. I have read and understand the above information and give Kids Care Dental permission to take photographs and x-rays.	
Signature (patient or guardian (if under 18)):	**Date:**