WELCOME TO OUR PRACTICE

WE 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.

FRASERBRACES—LOVE YOUR SMILE
ERIC D. FRASER, DDS, MS
Orthodontics for Children and Adults

Today's Date: ____/____/____

TELL US ABOUT YOUR CHILD

Date of Birth: ____/____/____

☐Male ☐Female

Child's Name: _____
LAST FIRST MI

Nickname: _____ SS#: _____

School: _____ Grade: _____

Hobbies:/Sports: _____

Child's Home #: (___) _____

Child's Home Address: _____

_____
CITY STATE ZIP

Email address: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____

Do You Have Legal Custody Of This Child? ☐Yes ☐No

Whom May We Thank For Referring You? _____

List Brothers/Sisters With Age: _____

_____

General Dentist: _____

Last Visit Date: _____

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

PARENT/GUARDIAN INFORMATION

☐Mother ☐Stepmother ☐Guardian

Name: _____ Birthdate: _____

Email address: _____

Cell #: (___) _____ Home #: (___) _____

Employer: _____ Work #: (___) _____

SS#: _____ DL #: _____

☐Father ☐Stepfather ☐Guardian

Name: _____ Birthdate: _____

Email address: _____

Cell #: (___) _____ Home #: (___) _____

Employer: _____ Work #: (___) _____

SS#: _____ DL #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Employer: _____

Work #: (___) _____ Ext: _____ SS#: _____

Who is responsible for making appointment? _____

Name: _____

Work #: (___) _____ Ext: _____ Home #: (___) _____

Neighbor or Relative not living with you:

Name: _____ Phone #: _____

Address: _____

_____
CITY STATE ZIP

ORTHODONTIC INSURANCE

Policy Owner's Birthdate: ____/____/____

Policy Owner's Employer: _____

Dental Coverage? ☐Yes ☐No Ortho Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS #: _____

Policy Owner's Employer: _____

SECONDARY INSURANCE

Dental Coverage? ☐Yes ☐No Ortho Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS #: _____

Policy Owner's Employer: _____

Continued on back

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS 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 instrument 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/tenderness in his/her jaw joint (TMJ/TMD)?
☐ Yes ☐No

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

Floss his/her teeth daily? ☐Yes ☐No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

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

Has puberty begun? ☐Yes ☐No

Has menstruation begun? (Girls) ☐Yes ☐No

Has your child ever taken Phen-Fen? ☐Yes ☐No

(Also known as Redux or Pondimin) If so, when? _____

Please describe your child's current physical health:

☐Good ☐Fair ☐Poor

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 MEDICAL PROBLEMS?

☐Y ☐N Abnormal Bleeding
☐Y ☐N ADD/ADHD
☐Y ☐N Allergic to any drugs
☐Y ☐N Allergic to Latex/Metals
☐Y ☐N Allergic to Plastic
☐Y ☐N Any Hospital Stays
☐Y ☐N Any Operations
☐Y ☐N Artificial Bones/Joints/
☐Y ☐N Asthma
☐Y ☐N Cancer
☐Y ☐N Congestive Heart Defect
☐Y ☐N Convulsions/Epilepsy
☐Y ☐N Diabetes
☐Y ☐N Handicaps/Disabilities
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Murmur
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis
☐Y ☐N HIV+/AIDS
☐Y ☐N Kidney Problems Valves
☐Y ☐N Liver Problems
☐Y ☐N Lupus
☐Y ☐N Rheumatic/Scarlet Fever
☐Y ☐N Sickle Cell Disease/Traits
☐Y ☐N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

DOES/DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

☐Y ☐N Clenching/Grinding Teeth
☐Y ☐N Lip Sucking/Biting
☐Y ☐N Thumb/Finger Sucking
☐Y ☐N Nail Biting
☐Y ☐N Nursing Bottle
☐Y ☐N Speech Problems
☐Y ☐N Mouth Breather
☐Y ☐N Tongue Thrust

Was your child breastfed? ☐Yes ☐No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. all benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

My method of payment will be: _____

_____
Signature of parent/guardian Date

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.

_____
Signature of parent/guardian Date

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT. 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.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

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