

Springwood Professional Center
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WELCOME

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SPECIALISTS IN ORTHODONTICS
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Liberty Professional Center
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(513) 755-9100

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Child or Teen

Child's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female Home Phone _____

Patient's Home Address _____ City _____ State _____ Zip _____

School _____ Hobbies _____

Who is completing this form? _____
First Middle Last

Relationship _____ Do you have legal custody? Yes No

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? Yes No If Yes, name _____

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

Has your child visited an orthodontist before? Yes No If Yes, for what reason? _____

Is there anything you would like to discuss with the doctor in private? Yes No

Parent Information

Marital Status of Parents: Single Married Widowed Separated Divorced Domestic Partner

Father

Father Step Father Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birth Date _____

Social Security Number _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Employer's Address _____

If you have Dental Insurance coverage for the child, please fill out:

Insurance Company Name & Address _____

Insurance Company Phone _____ Group # _____ Insured ID # _____

Mother

Mother Step Mother Guardian Name _____
First Middle Last

Address (if different than child's) _____ Birth Date _____

Social Security Number _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Employer's Address _____

If you have Dental Insurance coverage for the child, please fill out:

Insurance Company Name & Address _____

Insurance Company Phone _____ Group # _____ Insured ID # _____

Please complete both sides.

Dental and Medical History

Is the child currently under the care of a physician? Yes No If Yes, for what reason? _____

Child's Physician _____ Phone _____

History of major illness? Yes No If Yes, please describe _____

Any sensitivities or allergies? Yes No If Yes, please list _____

Currently taking any medications? Yes No If Yes, please list _____ Amount/Dose _____

Has puberty begun? Yes No

Has menstruation (period) begun? Yes No Not applicable

Does the child require antibiotics before dental treatment? Yes No If Yes, explain _____

Have the adenoids or tonsils been removed? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have there been injuries to the child's face, mouth or chin? Yes No

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

Check (✓) if your child ever had any of the following medical problems:

- | | |
|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies to any Drugs | <input type="checkbox"/> Handicaps / Disabilities |
| <input type="checkbox"/> Allergic to Latex / Metals | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Allergic to Plastic | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Any Hospital Stays | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Any Operations | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV positive / AIDS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney / Liver Problems |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Tuberculosis |

Check (✓) if your child has any of the following habits:

- | | |
|---|---|
| <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Nursing Bottle Habits |
| <input type="checkbox"/> Lip Sucking / Biting | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Mouth Breather | <input type="checkbox"/> Thumb / Finger Sucking |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Tongue Thrust |

Please discuss any medical problems that your child has had:

Signature

I understand that the information that I have provided 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 child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____

OFFICE USE ONLY

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

Doctor's Comments:
