hebron orthodontics

transforming great smiles for life

Tell Us About Your Child

Today's Date _____ Nickname _____

Child's Name _____ _____ _____
LAST FIRST MI

Child's Birthdate _____ Child's Age _____ M ☐ F ☐

Child's E-mail Address _____

School _____ Grade _____

Hobbies/sports: _____

Child's Hm #: (____) _____

Child's Home Address _____

_____ _____ _____
CITY STATE ZIP

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Y ☐ N ☐

Whom may we thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____

Dentist Ph: (____) _____ Last Visit Date: _____

What concerns you most about your teeth?

_____

Do you have a preference(s) for:

Invisalign ☐ Clear Braces ☐ Color on braces ☐

Any future special occasion(s) for us to consider

_____

When? _____

How motivated are you to start treatment?

(Highly) 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ (Uncertain)

Please rate what aspects of treatment are most important to you:

(5 – Most and 1 – Least)

Length of treatment:	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐
Low down payment:	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐
Low monthly payment:	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐
Quality of treatment:	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐

Referral Source:

Please check all that apply:

☐ My dentist recommended you.

☐ My friend, neighbor or co-worker recommended you. (Please specify whom) _____

_____

☐ A family member treated by Dr. To.

☐ Google reviews.

☐ Saw your sign while driving by.

☐ Invisalign referred me.

☐ I saw your website.

☐ You participate in my insurance plan.

☐ Heard about you through sports or community activity:

_____

☐ Received your postcard in the mail.

☐ School / Community Publication. (Specify) _____

☐ Other (Please elaborate) _____

_____

Parent's Information

Who is responsible for account? _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Stepfather ☐ Guardian

☐ Mother ☐ Stepmother

Name: _____ Birthdate: _____

Address: (If different than Child's) Hm #: (____) _____

_____

_____

Wk: (____) _____ Cell #: (____) _____

Email: _____

Employer _____ Occupation: _____

Employer Address: _____

_____ _____ _____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

Insurance Verification (Office Use Only)

Effective Date _____

Group _____

Lifetime Max _____

Paid @ (%) _____

Deductible ($) _____

Used to Date (*) _____

Age limit _____

Adult Coverage _____

Dental and Medical History

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

_____

Has you child ever been evaluated or had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Does the child require antibiotics before dental treatment? ☐Y ☐N

Have adenoids or tonsils been removed? ☐Y ☐N

Does your child have any missing or extra permanent teeth? ☐Y ☐N

Has the child ever had any pain/tendemess in his/her jaw joint (TMJ/TMD)? ☐Y ☐N

Does the child brush teeth daily? ☐Y ☐N Floss daily? ☐Y ☐N

Child's Physician: _____

Ph #: (_____) _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

GIRLS: Has menstruation begun? ☐Y ☐N

Indicate the child's current physical health: ☐Good ☐Fair ☐Poor

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

_____

Does your child have allergies to any of the following?

Latex ☐Y ☐N Nickel/Metals ☐Y ☐N Plastic ☐Y ☐N

Please list any other allergies that the child may have:

_____ _____

_____ _____

Has the child experienced the following medical problems?

Y☐ N☐	Abnormal Bleeding	Y☐ N☐	Hearing Impairment
Y☐ N☐	ADD/ADHD	Y☐ N☐	Heart Murmur
Y☐ N☐	AIDS/HIV+	Y☐ N☐	Hemophilia
Y☐ N☐	Any Hospital Stays/Operations	Y☐ N☐	Hepatitis
Y☐ N☐	Artificial Bones/Joints/Valves	Y☐ N☐	Kidney Problems
Y☐ N☐	Asthma	Y☐ N☐	Liver Problems
Y☐ N☐	Cancer	Y☐ N☐	Mitral Valve Prolapse
Y☐ N☐	Congenital Heart Defect	Y☐ N☐	Prosthetics
Y☐ N☐	Convulsions	Y☐ N☐	Rheumatic Fever
Y☐ N☐	Diabetes	Y☐ N☐	Scarlet Fever
Y☐ N☐	Epilepsy	Y☐ N☐	Sickle Cell Disease/Traits
Y☐ N☐	Handicaps/Disabilities	Y☐ N☐	Tuberculosis (TB)

Are the child's immunizations current? Y☐ N☐

Would you like to discuss anything with the Doctor in private? Y☐ N☐

Please list any serious medical problems the child has had:

_____

_____

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

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

List any musical instruments played:

_____

_____

_____

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.

ORTHODONTIC INFORMATION RELEASE PER HIPAA

Patient Name: _____ Date of Birth: _____

I authorize the release of information including diagnosis, records, claims and financial information. This information may be released to:

_____

_____

___I do not authorize the release of information to anyone.

This Release of Information will remain m effect until terminated by me in writing.

Signed: _____ Date: _____

OFFICE USE ONLY

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

SIGNATURE OF DOCTOR _____ DATE _____

Medical History Update

Has there been any change in your child's health status since their last visit? Y☐ N☐

If yes, please explain: _____

_____

_____ PARENT/GUARDIAN SIGNATURE _____ DATE

_____ DOCTOR SIGNATURE _____ DATE

Has there been any changes in your child's health status since their last visit? Y☐ N☐

If yes, please explain: _____

_____

_____ PARENT/GUARDIAN SIGNATURE _____ DATE

_____ DOCTOR SIGNATURE _____ DATE