WELCOME

To the office of Dr. Miriam Van Allen

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!

Tell Us About Your Child

Today's Date: _____ Nickname: _____

CHILD'S NAME: _____
Last First M.I.

E-mail: _____

Birthdate:___/___/___ Age: _____ □ Male □ Female

School: _____Grade: ____

Hobbies/Sports: _____

Child's Home #: (_____) _____

Home Address: _____

_____
City State Zip

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 □Partnered □Divorced □Married □Separated □Widowed

Mother's Information: □ Step Mother □ Guardian

Name: _____ Birthdate:__/__/___

Wk#: (___) _____ Ext: ___Hm#: (___) _____

Cell: (___) _____ Best # to Reach you 8-5PM: _____

Employer: _____

How long at current job: ____ Job Title: _____

SS #: _____ DL #: _____

Father's Information: □ Step Father □ Guardian

Name: _____ Birthdate:__/__/___

Wk#: (___) _____ Ext: ___Hm#: (___) _____

Cell: (___) _____ Best # to Reach you 8-5PM: _____

Employer: _____

How long at current job: ____ Job Title: _____

SS #: _____ DL #: _____

Person Responsible for Account

Name: _____Relation: _____

Billing Address: _____

_____
City State Zip

Previous Address: _____

_____
City State Zip

Hm #:(____) _____DL #: _____

Employer: _____

Wk #: (____)_____Ext: ___SS#: _____

Who is responsible for making appointments?

Name: _____

Wk#: (___) _____ Ext: ___Hm#: (___) _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? □ Yes □ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group #: _____

Policy Owner's name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/___SS #:_____

Employer's Address: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? □ Yes □ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group #: _____

Policy Owner's name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/___SS #:_____

Employer's Address: _____

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 instruments 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: _____

Ph.#: (___) _____ **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

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:

_____

Y / N – Latex Y / N – Metals/Nickel Y / N - Plastics

Has your child ever had any of the following medical problems?

Y	N	Abnormal bleeding	Y	N	Convulsions/Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	handicaps / Disabilities
Y	N	Allergic to Latex/Metals	Y	N	Hearing impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints	Y	N	HIV+ / AIDS
		Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis

Please discuss any medical problems that your child has had:

_____

_____

_____

Has your child ever experienced any of the following?

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

Neighbor or Relative NOT living with you:

Name: _____

Phone: (____) _____

Address: _____

_____

City State Zip

I understand that the information given 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 authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or 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 or guardian Date

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.

_____

Signature of parent or guardian Date

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 parent / guardian and patient named herein.

Doctor's Comments: **Initials:** ____ **Date:** _____

_____

_____

_____