WELCOME
Stephen J. Harper DDS
ORTHODONTIST

Tell Us About Your Child

Today's Date:_____ Nickname:_____
Child's Name:_____
Birthdate:_____ Age:_____ Male () Female ()
E-mail Address: _____@_____.com
School:_____ Grade:_____
Hobbies/Sports:_____
Child's Home #: ( )_____SS#:_____
Child's Home Address:_____
_____

General Information

Who is accompanying the child today?
Name:_____ Relation:_____
Do you have legal custody of this child? Yes () No ()
Whom may we thank for referring you?_____
Other Siblings:_____
General Dentist:_____
Dentist Phone #:(___)_____ Last Visit date:_____
Relative or friend not living with you:
Name:_____Phone(___)_____
Address:_____
_____

Parent's Information

Who is responsible for the account?_____

Parent's Marital Status: () Single () Married () Partnered () Widowed () Divorced () Separated

() Father () Stepfather () Guardian
Name:_____ Birthdate___/___/___
Address (If different than child's):
_____
_____
SS#:_____DL#_____
Wk#:(___)_____ Ext:_____ Hm#:(___)_____
Email:_____@_____.com Cell#:(___)_____
Employer:_____ Occupation:_____
Employer Address:_____
_____
If you have orthodontic Insurance Coverage for the child, please fill out below:
Insurance Co. Name:_____
Insurance Address:_____
_____
Insurance Phone:(____)_____
Group#(plan, local, or policy)_____

() Mother () Stepmother () Guardian
Name:_____ Birth date___/___/___
Address (If different than child's):
_____
_____
SS#:_____DL#_____
Wk#:(___)_____ Ext:_____ Hm#:(___)_____
Email:_____@_____.com Cell#:(___)_____
Employer:_____Occupation:_____
Employer Address:_____
_____
If you have orthodontic Insurance Coverage for the child, please fill out below:
Insurance Co. Name:_____
Insurance Address:_____
_____
Insurance Phone:(____)_____
Group#(plan, local, or policy)_____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents 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. If this office accepts insurance, I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the Dr. Stephen Harper to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature_____ Date_____

Dental & Medical History

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

_____

Has your child ever been evaluated for orthodontic treatment before? Yes ☐ No ☐

Have there ever been any injuries to the face, mouth, teeth, or chin? Yes ☐ No ☐

Does the child require antibiotics before dental treatment? Yes ☐ No ☐

Have adenoids or tonsils been removed? Yes ☐ No ☐

Does your child have any missing or extra permanent teeth? Yes ☐ No ☐

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

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

Floss his/her teeth daily? Yes ☐ No ☐

Child's Physician:_____ Phone #:_____

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

Has puberty begun? Yes ☐ No ☐ Has menstruation begun? Yes ☐ No ☐

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

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

_____

Aside from item listed below, list all drugs/ things your child is allergic to:_____

_____

Latex: Yes No **Nickel/Metals:** Yes No **Plastic:** Yes No **Milk:** Yes No

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest confidence and that 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/orthodontic services my child may need.

_____

Signature of Parent or Guardian Date

Has the child experienced the following medical problems?

Y N Abnormal Bleeding	Y N Heart Impairments
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 MVP
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
Y N Handicaps/Disabilities	Y N Tuberculosis

Has the child ever taken any diet pills such as Phen- Fen? Yes ☐ No ☐
(Also known as Redux or Pondinin.) If so when?_____

Are the child's immunizations current? Yes ☐ No ☐

Anything you would like to discuss with the doctor in private? Yes ☐ No ☐

Please discuss any serious medical problems the child has had:

_____

_____

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

Y N Breast Fed	Y N Nursing Bottle 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 Used Pacifier

List any musical instruments played: _____

_____

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

_____

Signature of Dentist Date

Dentist's comments: _____

_____

_____