CHILD PATIENT INFORMATION

(All information will be kept completely confidential)

Patient Name: ____ Child prefers to be called: ____________________________
First Last
Sex: Male Female
Address: ____ City: _______________ State: _________ Zip: _____________
Parent's Cell Phone #: _______________________________ Home Phone #:__ _________________________ Age: _______
Grade: _________ Birthdate: _______________________ School: ____
Sports/Hobbies: ____
Father's Name: ___________________________________ Employer: ____________________ Work Phone: ______________
First Last
Mother's Name: _____________________________ Employer: ________________ Work Phone: _____ __________________
First Last
Parent's Marital Status: Single Married Divorced Separated Widow(er)
Other children in family: Names/Ages: (___________ /____ yrs) (__________ /____ yrs) (___________ /____ yrs)
Emergency Contact: Name: _________________________ Relationship: ________________ Phone #: ____________________
Parent Email Address: ____

If another person will be responsible for payment of this account, please complete the following:
Name: ____
Address: _______________________________________ City: _____________________________ State _________________
Zip: _____________ Home Phone: ____________________________ Age: ___________ Birthdate: ____________________
Employer: ____ Bus. Phone: ____________________________

How did you hear about our office? ____
Whom may we thank for your referral? ____
Please describe your child's dental problem(s) and/or concerns:
____
____

DENTAL HISTORY

Name of Child's General Dentist: ____
(Circle appropriate information)
Frequency of dental checkups: Twice a year / Once a year / Only if a problem arises / Never
Date of last cleaning: ____
Is there any unfinished care to be completed with your child's dentist? No Yes
Explain: ____
Does your child need Antibiotics for dental visits or cleanings? No Yes
Explain: ____
Has your child had any facial or dental injuries? No Yes
Explain: ____
Is there any history of thumb or finger sucking? No Yes
Explain: ____
Has your child consulted an orthodontist previously? No Yes
When: ____
Does your child want orthodontic treatment? No Yes
Explain: ____
Please **circle** if there is a history of:

Clenching teeth Jaw joint clicking Jaw joint soreness Jaw joint popping Grinding teeth
Ringing in the ears Frequent Headaches Muscular Soreness (around head & neck) Trauma to Face
Speech problems (if so, which sounds) __________________ Mouth Breathing while: Awake Asleep

Please Turn Over

Your answers to the following questions will help Dr. Renjen to select the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

MEDICAL HISTORY

Name of Child's Physician: ________________________________ Physician's Phone #: ____________________________

Allergic to Latex or Nickel (costume jewelry)? No Yes
Explain: ____
Serious illness or hospitalization? No Yes
Explain: ____
Child taking any drugs or medication? No Yes
List Drugs: ____
Allergy to Penicillin or other drugs? No Yes
List
Drugs: ____
Rheumatic fever, heart disease, heart murmur? No Yes
Explain: ____
Tonsils and/or Adenoids removed? No Yes
When: ____
Any learning disorders or emotional problems? No Yes
Explain: ____
Is child sensitive/self-conscious about their smile? No Yes
Explain: ____
Birth defects or hereditary problems (e.g. Cleft Lip/Palate)? No Yes
Explain: ____
History of any Bone disorders ? No Yes
Explain: ____
Tuberculosis/ Hepatitis B or C/ HIV Infection? No Yes
Explain: ____

Child's Growth and Development:

Females: Menstruation begun?(Growth spurt indicator) No Yes At what age? ______________________________
Mental/Emotional development compared to other children their age? Ahead / Average / Behind
Physical development compared to other children their age? Ahead / Average / Behind
Patient's Height: __________________ Mother's Height: ______________________ Father's Height: __________________
Any other health problems or special concerns: ____
____
____

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services rendered are charged directly to the parent/guardian and the parent/guardian is responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. In order to do so, please sign below authorizing Renjen Orthodontics to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I have read and understand the above questions. If there are any future changes to my medical or dental status I will inform the Dr. and/or staff of Renjen Orthodontics. I certify the above information is correct.

Parent's Signature: ____

Date: ____

Primary Insurance Carrier __________________________ Secondary Insurance Carrier ____________________________

Subscriber ID # ___________________________________ Subscriber ID # _______________________________________

Group ID # _______________________________________ Group ID # ____

Social Security/ID # _______________________________ Social Security/ID # ____________________________________

Primary Insurance Holder ___________________________ Secondary Insurance Holder _____________________________

Primary Insurance Holder's DOB _____________________ Secondary Insurance Holder's DOB ________________________