1500 West 12th Street
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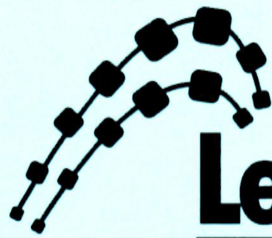

LeBlanc
ORTHODONTICS

Tell Us About Your Child

Today's Date ___/___/___ Nickname ______________

Child's Name ______________

Child's Birthdate ___/___/___ Child's Age ______ ❑ M ❑ F

E-mail Address ______________

School ______________ Grade ______

Hobbies/sports ______________

Child's Home #: (___)__________ SS# __________

Child's Home Address ______________
CITY STATE ZIP

General Information

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 ______

Relative or friend not living with you:

Name ______________ Ph. (___)__________

Address ______________

____
CITY STATE ZIP

Parent's Information

Who is responsible for account? (Name) ______________

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

❑ Father ❑ Stepfather ❑ Guardian

Name ______________ Birthdate ___/___/___

Address (If different than Child's) Home # (___)__________

____

____

SS # __________ DL # __________

Work # (___)__________ 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 ______________

____
CITY STATE ZIP

Ins. Ph. (___)__________ Insured's ID # __________

Group # (Plan, Local or Policy #) ______________

❑ Mother ❑ Stepmother ❑ Guardian

Name ______________ Birthdate ___/___/___

Address (If different than Child's) Home # (___)__________

____

____

SS # __________ DL # __________

Work # (___)__________ 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 ______________

____
CITY STATE ZIP

Ins. Ph. (___)__________ Insured's ID # __________

Group # (Plan, Local or Policy #) ______________

Authorization

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 the office, use the services of one or more credit reporting services. 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, including the deductible. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. Also, I assign directly to the doctor all insurance benefits otherwise payable to me. I understand that I am responsible for all costs of orthodontic treatment. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________ ______
SIGNATURE DATE

CONTINUED ON BACK

Dental and Medical History

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

____

____

Has your child ever been evaluated for 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 the child have any missing or extra permanent teeth? ❑ Y ❑ N

Has the child ever had any pain/tenderness 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/Hemophilia	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)

Has the child ever taken any diet pills such as Phen-Fen ❑ Y ❑ N

(Also known as Redux or Pondimin) If so, when? ____________________

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 condition(s) the child has ever 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 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.

The information I have given is correct to the best of my knowledge. I understand that this information will be held in the 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 that my child may need.

____

SIGNATURE OF PARENT OR GUARDIAN DATE

Office Use Only

Doctor's Comments ________________________________

____

____

____

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 health status since your last visit? ❑ Y ❑ N

If Yes, please explain ________________________________

____

Has there been any change in your health status since your last visit? ❑ Y ❑ N

If Yes, please explain ________________________________

____

____

Parent Signature Date

____

Doctor Signature Date

____

Parent Signature Date

____

Doctor Signature Date