webb ORTHODONTICS

Child Information Form

Date_____

WELCOME!

To assist us in providing the most complete service, please provide the following information and health history

Patient Name (First, Middle, Last)_____Nickname_____

Birth Date_____Age_____Gender: **M** or **F** School_____

Grade_____ Adopted? **Y** or **N** - At What Age?_____Brothers/Sisters (Name and Age) _____

Dentist_____Physician _____

Who should we thank for referring you? _____

Mother Information

Name_____

Address _____

City/State_____Zip_____

Email_____Best Phone_____

Employer_____

Mother DOB_____SS # _____

Marital Status:_____

O Single O Married O Separated O Divorced O Widowed

Father Information

Name_____

Address_____

City/State_____Zip_____

Email_____Best Phone _____

Employer _____

Father DOB_____SS #_____

Marital Status: _____

O Single O Married O Separated O Divorced O Widowed

Person <u>financially</u> responsible for the account: _____

Signature:_____**Date:** _____

Primary Dental Insurance Only

Orthodontic Coverage? ☐ Yes ☐ No

If "Yes" please complete below:

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insurance ID #_____

Policy Owner's Name_____

Relationship to Patient _____

Policy Owner's DOB_____SS# _____

Policy Owner's Employer_____

<u>FOR OFFICE USE ONLY</u>

____% ____Age ____Max ____How much met? _____

WPE: **Y** or **N** Waiting: **Y** or **N**

Insurance Verification: **<u>Submit</u>** OR **<u>Auto</u>**

Date_____Effective Date_____Ded _____

How to bill: Mos_____ Qtr_____ 6 Mos_____ Annual _____

Payer ID_____ Carrier #_____

Claims: _____

_____

_____

_____

Michael A. Webb DDS, MS
Colin M Webb DDS, MS

www.webb-orthodontics.com **(704) 364-7343**

Medical History

O Adenoids Removed
O Anemia
O Asthma
O Bone Disorders
O Birth Abnormalities
O Diabetes
O Fainting/Dizziness
O Epilepsy
O Earaches
O Joint Swelling
O Hepatitis
O Heart Trouble
O Emotional Problems
O Tonsils Removed
O Endocrine Problems
O Tonsillitis
O Sore Throats
O Prolonged Bleeding
O Thyroid Problems
O Rheumatic Fever
O Positive HIV Test
O Kidney or Liver Disease

List any other serious illnesses:

_____

Allergies to: Latex/Metal/Drugs/Local Anesthetics (circle)

Other Allergies:_____

Current Drugs/Medications_____

Comments _____

Other Information

Patient's Attitude Towards Treatment (Circle One)

Wants it Done Today! Does Not Care Not too Thrilled. . .

What is Your Biggest Concern?

_____

_____

_____

Sports or Physical Activities_____

Any Wind Instruments played _____

Approximately how much has the patient grown in the last year?

_____

If female, has the patient had her first menstrual cycle?

O Yes O No If so, when was it?_____
This aids us in predicting growth.

Any other important information

_____

_____

_____

_____

Dental History

O Any thumb/finger sucking habits?_____

O Any injuries to face, mouth, teeth? (circle)

O Mouth breathing when awake, asleep? (circle)

O More than average amount of decay/cavities?

O Any missing permanent teeth? _____

O Any extra permanent teeth?_____

O Any teeth removed by extraction? _____

O Is there any tongue-thrusting issues? _____

O Any speech difficulties? _____

O Any difficulty swallowing or chewing? _____

O Any pain or clicking on opening/closing mouth? (circle)

O Does patient visit dentist regularly? Recent date _____

O Any previous orthodontic treatment/consultation? (circle)

Reason_____

Currently Under Physician's Care? O Yes O No

Physician_____Reason _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

X_____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 the office, use the services of one or more credit reporting services.

X_____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.

X_____Date_____