STAMFORD ORTHODONTICS

Welcome to Stamford Orthodontics, where we take pride in creating healthy beautiful smiles that will last a lifetime. We hope your visit is a pleasant and educational experience.

Tell Us About Your Child

Today's Date: ____/____/_____ Nickname_____

Child's Name:_____
Last First MI

Child's Birthdate: ____/____/____Child's Age:_____ ☐Male ☐Female

Email Address: _____

School:_____ Grade:_____

Hobbies/Sports_____

Child's Home # (____)_____SS #_____

Child's Address_____
Apt.#

_____
City State Zip

General Information

Who is accompanying the child today?

Name:_____ Relation:_____

Do you have legal custody of this child? ☐ Yes ☐No

Who may we thank for referring you?_____

Other Siblings/Ages _____

General Dentist:_____Last Visit_____

Dentist's Phone # (____)_____

Relative or Friend not living with you:

Name:_____Phone: (____)_____

Address:_____
Apt.#

_____
City State Zip

Parent/Guardian Information

Who is responsible for account? _____ Parent's Marital Status ☐ Single ☐ Married ☐Partnered ☐Divorced ☐Widowed ☐Separated

☐ Father ☐ Step Father ☐ Guardian

Name_____Birthdate ____/____/_____

Address: (If different than Child's) Home# _____

_____
Apt.#

_____
City State Zip

SS #_____ DL# _____

Wk # (_____)_____Ext____Cell# (____)_____

Email:_____

Employer_____Occupation_____

Employer's Address_____

_____
City State Zip

☐ Mother ☐Step Mother ☐Guardian

Name_____Birthdate ____/____/____

Address: (If different than Child's) Home# _____

_____
Apt.#

_____
City State Zip

SS #_____ DL# _____

Wk # (_____)_____Ext____Cell# (____)_____

Email:_____

Employer_____Occupation_____

Employer's Address_____

_____
City State Zip

If you have Orthodontic Insurance Coverage for the child fill out below:

Insurance Co. Name:_____

Insurance Address:_____

_____
City State Zip

Insurance Phone(____)_____Insured's ID#_____

Group# (Plan, Local, or Policy #) _____

If you have Orthodontic Insurance Coverage for the child fill out below:

Insurance Co. Name:_____

Insurance Address:_____

_____
City State Zip

Insurance Phone(____)_____Insured's ID#_____

Group# (Plan, Local, or Policy #) _____

Authorization

If this office accepts my 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. 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 of Parent or Guardian_____**Date**_____

Dental and Medical History

The following information is for our office records only, and is confidential.

Child's physician:_____ Doctor's Phone #_____
List medication, nutritional supplements, herbal medications, non-prescription medicines, including flouride supplements that your child takes:

_____

How would you describe your child's physical health? Circle: Good Fair Poor

List all drugs/food, etc. that child is allergic to:_____

Is your child allergic to: Latex Y N Nickel/Metals Y N Plastic Y N

What are your main concerns about your child's teeth? _____

Y N Has your child had any past orthodontic treatment or consult?

Y N Have adenoids or tonsils been removed?

Y N Have there been any injuries to the face, mouth, teeth or chin?

Y N Has he/she had any pain/tenderness in the jaw joint?

Has your child experienced the following medical conditions?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N AIDS/HIV
Y N Surgery
Y N Bone fractures, or major injuries
Y N Arthritis or joint problems
Y N Cancer, tumor, radiation treatment or chemotherapy
Y N Endocrine or thyroid problems
Y N Diabetes or low sugar
Y N Kidney problems
Y N Congenital Heart Defect
Y N Convulsions
Y N Tuberculosis
Y N Frequent ear infections, colds, throat infections
Y N Epilepsy
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sickle Cell Disease/Traits
Y N Immune System problems
Y N High or low blood pressure

Please discuss any serious medical problems the child has had:_____

_____

Does your child experience any of the following: (Circle) Grinding Teeth Mouth Breathing Thumb Sucking Nail Biting

List any wind/brass instruments played: _____

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent or Guardian_____ **Date**_____

For Office Use Only

I have verbally reviewed the medical/dental information above with the parent/guardian named herein.

Signature of Dentist_____**Date**_____

Medical History Update

Change in Health Status: _____

Dentist Signature_____Date_____ Parent/Guardian Signature_____Date_____

Change in Health Status: _____

Dentist Signature_____Date_____Parent/Guardian Signature_____Date_____