

# WELCOME

*We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information - Child or Teen

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Middle Last

Nickname (if preferred) \_\_\_\_\_ Male Female Patient's Home Phone \_\_\_\_\_

Patient's Home Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Street

Who is filling in this form? Name \_\_\_\_\_  
First Middle Last

Relationship \_\_\_\_\_ Do you have legal custody? YES NO

Patient's General Dentist \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Have we treated another member of your family? YES NO If YES, Name \_\_\_\_\_  
First Middle Last

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

Has your child visited an orthodontist before? YES NO If YES, for what reason? \_\_\_\_\_

Anything you would like to discuss with the doctor in private? YES NO

## Parents Information

Marital Status      Single      Married      Widowed      Divorced      Separated      Domestic Partner

### Father

Father      Step Father      Guardian      Name \_\_\_\_\_  
First Middle Last

Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_

**If you have insurance coverage for the child, please fill out.**

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

### Mother

Mother      Step Mother      Guardian      Name \_\_\_\_\_  
First Middle Last

Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_

**If you have insurance coverage for the child, please fill out.**

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

## Dental and Medical History

Is the child currently under the care of a physician?      YES      NO      If YES, for what reason? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

History of major illness?      YES      NO      If YES, please describe \_\_\_\_\_

Any sensitivities or allergies?      YES      NO      If YES, please list \_\_\_\_\_

Currently taking any medications?      YES      NO      If YES, please list \_\_\_\_\_ Amount/Dose \_\_\_\_\_

Has Puberty Begun?      YES      NO

Has menstruation (period) begun?      YES      NO      NOT APPLICABLE

Has the child been treated for any of the following?

Arthritis                      Blood Disorder                      Diabetes                      Heart Condition                      Tuberculosis

Asthma                      Cancer                      Epilepsy                      Nervous Disorder

Does the child require antibiotics before dental treatment?      YES      NO      If YES, explain \_\_\_\_\_

Have the adenoids or tonsils been removed?      YES      NO

Have you been informed of any missing or extra permanent teeth?      YES      NO

Have there been injuries to the child's face, mouth or chin?      YES      NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)      YES      NO

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

Grinding Teeth                                      Finger/Thumb Sucking                                      Prolonged Bottle/Pacifier

Mouth Breather                                      Speech Problems                                      Chewing/Eating Problems

## Signature

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

**I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office of Dr. Oliver Favalli.**

Signature \_\_\_\_\_ Date \_\_\_\_\_