WELCOME TO CAPPS ORTHODONTICS

CHILD PATIENT INFORMATION

Name:_____ Prefer to be called:_____ Sex:_____

Age:_____ Birthdate:_____ School:_____ Grade:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Patient resides with: □ Mother □ Father □ Both □ Other:_____

Responsible Party primary Phone:_____ Responsible Party E-mail:_____

Patient's Dentist:_____

Describe your child's orthodontic problem:_____

Patient's interests:_____

Whom may we thank for referring you to our office?_____

Parents and Account Information

Parent's Marital Status: □ Married □ Separated □ Divorced □ Widowed

	FATHER	MOTHER
Name:	_____	_____
Address (if different than above)	_____	_____
Phone (if different than above)	_____	_____
Social Security Number:	_____	_____
Employer's Name:	_____	_____
Business Address:	_____	_____
Business Phone:	_____	_____
Occupation:	_____	_____
How long with this employer:	_____	_____
Person responsible for account:	_____	_____

If other than parent:
Name: _____Address: _____Phone: _____
In case of an emergency, please provide name, address and phone number of your nearest relative:
Name: _____Address:_____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):_____

Date of Birth: _____ Social Security#_____-_____-_____

Name of insurance company:_____ Group #: _____ ID#:_____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name: _____ Address: _____ Phone: _____
Has your child experienced any health problems? □ No □ Yes Explain: _____
Any major change in your child's health recently? □ No □ Yes Explain: _____
Is your child currently under a physician's care? □ No □ Yes Explain: _____
Is your child currently taking any medications? □ No □ Yes Explain: _____
Is your child allergic to any medications? □ No □ Yes Explain: _____
Has your child received a blood transfusion? □ No □ Yes Explain: _____
Have your child's tonsils or adenoids been removed? □ No □ Yes Explain: _____

Please check if your child has had any of the following conditions:

Heart Murmur……..……□ No □ Yes	Hepatitis…….…..□ No □ Yes	Emotional Problems…. □ No □ Yes
Heart Surgery…….……..□ No □ Yes	Diabetes.…….…..□ No □ Yes	Frequent Headaches…. □ No □ Yes
Rheumatic Fever…..……□ No □ Yes	Kidney Disease…□ No □ Yes	Nervous/Anxious…..…. □ No □ Yes
Endocrine disorders……□ No □ Yes	Liver Disease...…..□ No □ Yes	Cancer……..…. □ No □ Yes
Prolonged Bleeding……□ No □ Yes	Tuberculosis…….□ No □ Yes	Bone Disorders……. □ No □ Yes
Anemia……...……□ No □ Yes	Bronchitis…….□ No □ Yes	Growth Disorders……. □ No □ Yes
Blood Disease……□ No □ Yes	Asthma…….□ No □ Yes	Mouth Breather…...…. □ No □ Yes
Developmental Disorder.□ No □ Yes	Epilepsy...…….□ No □ Yes	Herpes (Fever Blisters). □ No □ Yes
Hives/Rash….……□ No □ Yes	Fainting...…….□ No □ Yes	Tonsillitis……..…. □ No □ Yes

Is there any other condition or problem that you think we should know about? _____

Growth Information for Patients Under 16 Years of Age:
Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in selection of treatment alternatives.
Has your son or daughter reached puberty? □ No □ Yes
Girls- Has she started menstruation? □ No □ Yes When? _____
Boys- Has his voice changed? □ No □ Yes When? _____
Father's Height_____ Mother's Height_____ Adopted □ No □ Yes
Names and Birthdates of patient's brothers and sisters: _____
Have either siblings or parents had orthodontic treatment? □ No □ Yes With Whom? _____

Dentist's Name: _____ Address: _____ Phone: _____
Dental checkups: □2 times a year □1 time a year □Only if problem exists □Never Date of Last Visit:_____
Is there any unfinished care to be completed with your child's dentist? □ No □ Yes Explain: _____
Is your child frightened about dental treatment? □ No □ Yes Explain: _____
Has your child had an unpleasant experience in the dental office? □ 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: _____
Does your child play any musical instruments? □ No □ Yes Explain: _____
Has your child consulted an orthodontist previously? □ No □ Yes Explain: _____
Have teeth (either primary or permanent) been removed? □ No □ Yes Explain: _____
Has your child had any previous orthodontic treatment? □ No □ Yes Explain: _____
Are you satisfied with prior treatment? □ No □ Yes Explain: _____
Any changes in your child's bite or dental alignment recently? □ No □ Yes Explain: _____

Please check if there is a history of:
□ Clenching teeth □ Muscular Soreness around head & neck □Jaw joint soreness □Jaw joint popping
□ Grinding teeth □ Headaches (more than normal) □Jaw joint clicking □Ringing in the ears
□ Speech problems (if so what sounds _____) □Mouthbreathing Awake_____ Asleep_____
Is there any other information which may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

_____ _____
Parent Signature **Date** **Reviewed by**