

Welcome

Lake Oswego Orthodontics



1 About Your Child

Today's Date _____ Nickname _____

Child's Name _____

Date of Birth _____ M, ___ F

School _____ Grade _____

Hobbies/Sports _____

Child's Home # _____

Phone # to Confirm Appointment _____

Contact Person to Confirm Appointment _____

Child's Home Address _____

General Dentist _____

Phone _____ Last Visit Date _____

What are the main concerns for this orthodontic consultation?

2 Who is Accompanying Your Child today?

Name _____ Relation _____

Who may we Thank for referring you?

___ Dentist, ___ Friend name _____, ___ Insurance

___ Internet Listing _____, ___ Mailing Brochure

___ Phone Book/Qwest, ___ Phone Book/Verizon

___ School Carnival, ___ Sign in the Building

3 Mother's Information _____ Step Mother, ___ Guardian

Name _____

Work # _____ Home # _____

Father's Information _____ Step Father, ___ Guardian

Name _____

Work # _____ Home # _____

Parent's Marital Status ___ Married, ___ Divorced, ___ Separated

4 Primary Responsible Party

Name _____ Relation _____

Billing Address _____

Home # _____ Work # _____

Secondary Responsible Party

Name _____ Relation _____

Billing Address _____

Home # _____ Work # _____

5 Primary Orthodontic Insurance

Insurance Co. Name _____

Phone # _____

Claim Address _____

Policy Owner's Name _____

Employer _____ Group # _____

ID or SSN _____ Date of Birth _____

Secondary Orthodontic Insurance

Insurance Co. Name _____

Phone # _____

Claim Address _____

Policy Owner's Name _____

Employer _____ Group # _____

ID or SSN _____ Date of Birth _____

By signing below, you agree to authorize the orthodontist to release any information from the diagnosis and records to any third party dental insurance group you belong to with the benefits payable to the orthodontist for treatment rendered within the office.

Signature _____ **Date** _____

6 Dental History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

- Teeth Grinding or Clenching
- Sore and or tender Jaws
- History of TMJ problems
- Gum disease
- Bleeding gums
- Fear of dental treatment
- Sore teeth
- Sensitive teeth
- Mouth breathing
- Mouth blistering or ulcers
- Finger or lip sucking
- Tongue thrusting habit
- Gag easily
- Bad Breath

Brush teeth daily __Y, __N Floss teeth daily __Y, __N

Prior orthodontic treatment, explain _____

Prior oral surgery, explain _____

Other, explain _____

8 Medical History

Please check if your child had or currently have any of the follow conditions, and date it was diagnosed

- High blood pressure
- Chest Pains
- Stroke
- Rheumatic Fever
- Shortness of Breath
- Heart Trouble or Murmur
- Prosthetic Device
- Need antibiotics before dental treatment __Y, __N
- Lung disease
- Asthma
- Allergy to Latex
- Other allergy or hay fever, explain _____
- Sinus Problem
- Ulcers or stomach problems
- Diabetes
- Hepatitis or liver disease
- Kidney disease
- Thyroid trouble
- Sexually transmitted disease
- Arthritis
- Cancer
- Bruise easily, prolonged bleeding
- Glaucoma
- Epilepsy
- Psychiatric therapy
- Exposed to HIV
- HIV or AIDS
- Possibly pregnant
- Take birth control pills
- Joint disease
- Other, explain _____
- None of the above**

7 Current Medications

Child's Physician _____

Phone _____

Please list all current medications and the medical conditions for its use _____

9 I understand that the information that I have given is correct, and it is my responsibility to inform this office of any changes in my child's dental and medical status, and medications. I authorize the orthodontist and staff to perform the services for my child.

Signature _____ Date _____

10 I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my orthodontic insurance does not cover.

Signature _____ Date _____