CAMINO REAL ORTHODONTICS

MICHAEL HASSEY • DDS
Diplomate, American Board of Orthodontics

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
First Middle Last (Nickname)

Birthdate: _____/_____/_____ Male □ Female □

Child's Home #: (_____)_____ SS #: _____

Child's Home Address: _____

_____
CITY STATE ZIP

Previous/Present Dentist:_____ Previous/Present Oral Surgeon:_____ Previous/Present Periodontist:_____

Last Date Seen by General Dentist:_____ Who may we **Thank** for referring you?: _____

List Family Members that are currently in our practice?: _____

Has either parent had Orthodontic Treatment?:_____ Has your child had previous Orthodontic Treatment? Yes □ No □

What are your chief complaints you would like to discuss with the Doctor?: _____

_____

Has your child ever had the following medical problems?

Y N Abnormal Bleeding	**Y N** Allergies to any drugs	**Y N** Any Hospital Stays
Y N Any Operations	**Y N** Asthma	**Y N** Cancer
Y N Congenital Heart Defect	**Y N** Convulsions / Epilepsy	**Y N** Diabetes
Y N Handicaps / Disabilities	**Y N** Hearing Impairment	**Y N** Heart Murmur
Y N Hemophilia	**Y N** Hepatitis	**Y N** HIV+ / AIDS
Y N Kidney / Liver Problems	**Y N** Rheumatic / Scarlet Fever	**Y N** Tuberculosis (TB)
Y N Frequent Colds	**Y N** Frequent Sore Throats	**Y N** High/Low Blood Pressure

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

_____

Has the child had any injuries to the face, mouth, or teeth? Yes □ No □ If yes, please explain:_____

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that the child is allergic to: _____

How many times does the child brush his/her teeth daily?:_____ How many times does the child floss his/her teeth daily?:_____

Has the child ever has any pain/tenderness in his/her jaw joint (TMJ / TMD)?: Yes □ No □

Does the child have the following habits? If yes, till what age?:_____

Y N Lip Sucking / Biting **Y N** Nail Biting **Y N** Nursing Bottle Habits **Y N** Thumb / Finger Sucking

Responsible Party Information

Mother's Name: _____ Birthdate: _____/_____/_____

Home #: (_____)_____ Work #: (_____)_____ Ext.: _____

SS #: _____ Employer: _____

DL#: _____ Step Mother □ Guardian □

Father's Name: _____ Birthdate: _____/_____/_____

Home #: (_____)_____ Work #: (_____)_____ Ext.: _____

SS #: _____ Employer: _____

DL#: _____ Step Father □ Guardian □

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

Who is financially responsible for charges?: _____
Name Relation to Patient

If different from above, Billing address: _____

_____
CITY STATE ZIP

Who is Responsible for making appointments?: _____
Name Relation to Patient

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #: (_____)_____

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

_____

Policy Owner's Name:

_____
First Middle Last

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/_____

SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes □ No □

Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #: (_____)_____

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

_____

Policy Owner's Name:

_____
First Middle Last

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/_____

SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes □ No □

I understand that the information that I have given 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 history or medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date