RICHARDS & ASSOCIATES ORTHODONTICS

--CHILD PATIENT INFORMATION—

Patient's Name:_____Nickname_____

Date of Birth_____ Age_____Sex_____

Mailing Address:_____

City_____State_____Zip_____

Phone Number:_____(Mobile, Home, Business-circle one)

School:_____Grade:_____

Current Dentist:_____Dentist Phone Number:_____

Who may we thank for referring this patient?_____

--FINANCIAL INFORMATION--

Orthodontic Insurance? Insurance Name_____

Employer_____Subscriber ID#:_____

Subscriber Name:_____Subscriber Birthdate:_____

Group #:_____Insurance Phone Number:_____

Parents: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Other

Patient's Father's Name_____

Father's Social Security #:_____Father's Birthdate:_____

Father's Address_____

Father's Phone Number:_____(Cell, Home, Business-circle one)

Father's Employer:_____ Email Address: _____

Patient's Mother's Name_____

Mother's Social Security #:_____Mother's Birthdate:_____

Mother's Address_____

Mother's Phone Number:_____(Cell, Home, Business-circle one)

Mother's Employer:_____Email Address:_____

PATIENT NAME:_____

--MEDICAL HISTORY--

Is the Patient in good health?_____
Have tonsils and/or adenoids been removed?_____
If presently under physician's care, state condition and duration_____
_____
Does patient have history of major illness/infectious diseases?_____
List any high fevers with childhood diseases_____
List any drugs or medications being taken and reasons_____
_____
List any allergies or drug sensitivities (e.g.. penicillin, novacaine)_____
List any learning disabilities_____
List any birth defects_____
List any psychological counseling_____
Check any of the following for which you have been treated and give age:

	Yes	No		Yes	No		Yes	No
HIV + Aids……	[ ]	[ ]	Bone Disorders…….	[ ]	[ ]	Kidney Problems……..	[ ]	[ ]
Fainting/dizziness…..	[ ]	[ ]	Pneumonia or TB…….	[ ]	[ ]	Nasal difficulty……..	[ ]	[ ]
Diabetes……	[ ]	[ ]	Nervous Disorders…..	[ ]	[ ]	Heart Trouble……..	[ ]	[ ]
Epilepsy……..	[ ]	[ ]	Endocrine Problems..	[ ]	[ ]	Hepatitis……..	[ ]	[ ]
Rheumatic Fever……..	[ ]	[ ]	Asthma……	[ ]	[ ]	Prolonged Bleeding…….	[ ]	[ ]
Dermatitis……	[ ]	[ ]						

Perferred Pharmacy:_____**Phone number:**_____
_____

--DENTAL HISTORY--

Did Father have an orthodontic problem?_____**Treated?**_____
Did Mother have an orthodontic problem?_____**Treated?**_____
Do any siblings have any orthodontic problems?_____**Treated?**_____
List other family members treated in this office_____
List names and ages of other children in family_____
Face and mouth most resemble: [ ]Father [ ]Mother [ ]Neither
List any injuries to face, teeth or mouth_____
Habits: [ ]Mouth breathing [ ]Grinding teeth [ ]Thumb or finger sucking (until what age)_____
List any speech problems_____
List any musical instruments played_____
Has an orthodontist been consulted previously: [ ]Yes [ ]No Whom?_____
Does patient vomit, gag or faint easily? [ ]Yes [ ]No
Have you been informed of any missing or extra permanent teeth? [ ]Yes [ ]No_____
Is patient especially apprehensive toward dental visits? [ ]Yes [ ]No
When did patient last have dental care?_____
By Whom_____**When is next scheduled visit?**_____
What do you feel may be the cause of the orthodontic problem?_____
What would you most like to have orthodontic treatment accomplish?_____
Most Important- does the patient want orthodontic treatment? [ ]Yes [ ]No

PATIENTS NAME:_____

--AUTHORIZATIONS—

I hereby authorize Richards & Associates Orthodontics to release a copy of my records to any treating physician/dentist, insurance company or other orthodontist, who may request these records pursuant to further medical or orthodontic care or treatment, and hereby release Richards & Associates Orthodontics and staff, from any and all responsibility that may arise from their compliance with this authorization. I hereby authorize Richards & Associates Orthodontics to use any of my x-rays or photographs in medical lectures /publications and for further educational purposes. I understand the Panorex taken at my new patient exam is at no charge but if the Panorex is requested to leave our office there will be a $175 charge.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**

--MEDIA CONSENT--

We have a website and a Facebook page and would love to share your/your child's smile.
[ ] I do give Richards & Associates Orthodontics permission to share my photos.
[ ] I do not give Richards & Associates Orthodontics permission to share my photos.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**