Hodges Orthodontics

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1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
Last First M. Ini.

Child's Birthdate: _____ Age _____

Nickname:_____ ❑ Male ❑ Female

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home#:_____

Child's Home Address:_____

_____
City State Zip

2 Who Is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ❑ Y ❑ N

Whom may we thank for referring you?

_____

List brothers/sisters with age:_____

_____

General Dentist:_____

Last Exam Date:_____Any cavities?_____

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

3 Parent's Information

Name:_____ DOB:_____

Relation to Patient:_____

Cell:_____ ❑ Call ❑ Voicemail ❑ Text

Employer:_____

Email:_____

Name:_____ DOB:_____

Relation to Patient:_____

Cell:_____ ❑ Call ❑ Voicemail ❑ Text

Employer:_____

Email:_____

4 Person Responsible For Account

Name:_____ Relation:_____

Billing Address:_____

_____
City State Zip

Previous Address:_____

Cell:_____ ❑ Call ❑ Voicemail ❑ Text

Employer:_____

Wk#:_____

Email:_____

5 Primary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group# (Plan, local, or Policy #):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's DOB:_____

Policy Owner's ID#:_____

Is there a secondary insurance? ❑ Yes ❑ No

6 Does/Did the Child Have Any of the Following?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Please Fill Out Page Two of This Form

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7 WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child even had any pain / tenderness in his / her jaw joint (TMI/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#:_____

Date of Last Visit:_____

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

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

_____

_____

8 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

Y N Abnormal Bleeding
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
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)

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

This office has my permission to use my photoraphs and records made in the process of examination, treatment and retention to be used for the purposes of research, education, or publication in professional journals.

_____

Signature of parent or guardian Date

530 E. Los Angeles Ave. #107
Moorpark, CA 93021

2277 Michael Drive #1
Newbury Park, CA 91320