BURKE + BECKSTROM ORTHODONTICS

This patient is a ☐ Kid ☐ Teen

Date ______

1 Patient Information

Tell us about your child:

Name ______ ☐ M ☐ F

Birthdate ___ / ___ / ___ Age ___ SS # ___

School ______ Grade ___

Hobbies / Sports ______

Musical Instruments Played ______

Child's Home Phone (___) ______

Child's Home Address ______
STREET APT #
CITY STATE ZIP

Parent's E-mail address ______

2 Responsible Party Information

Who is accompanying your child today?

Name ______

Relation to Patient ______

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

If divorce is involved, who is the custodial parent?

______

May patient information be released to non-custodial parent? ☐ Y ☐ N

Whom may we thank for referring you? ______

Other family members seen by us:

______

Parent's Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

3 Parental Information

☐ Mother ☐ Stepmother ☐ Guardian

Name ______

Birthdate ___ / ___ / ___ Age ___ SS # ___

Home Phone (___) ___ Work Phone (___) ___

Employer ______

Occupation ______ Years Employed ___

☐ Father ☐ Stepfather ☐ Guardian

Name ______

Birthdate ___ / ___ / ___ Age ___ SS # ___

Home Phone (___) ___ Work Phone (___) ___

Employer ______

Occupation ______ Years Employed ___

4 Person Responsible for Account

Name ______ SS # ___

Relation to Patient ______

Home Phone (___) ___ Work Phone (___) ___

Employer ______

Billing Address ______
STREET APT #
CITY STATE ZIP

Who is responsible for making appointments?

Name ______

Home Phone (___) ___ Work Phone (___) ___

5 Patient Orthodontic Insurance

PRIMARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name ______

Insurance Co. Address ______
STREET SUITE #
CITY STATE ZIP

Insurance Co. Phone (___) ______

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

Policy Owner's Name ______

Policy Owner's Relation to Patient ______

Policy Owner's Birthdate ___ / ___ / ___ ID # ___

Policy Owner's Employer ______

Employer Address ______
STREET SUITE #
CITY STATE ZIP

SECONDARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name ______

Insurance Co. Address ______
STREET SUITE #
CITY STATE ZIP

Insurance Co. Phone (___) ______

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

Policy Owner's Name ______

Policy Owner's Relation to Patient ______

Policy Owner's Birthdate ___ / ___ / ___ ID # ___

Policy Owner's Employer ______

Employer Address ______
STREET APT #
CITY STATE ZIP

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6 Emergency Contact Information

In the event of an emergency, whom should we contact?

Name ______________________________

Relation to Patient ______________ Phone (____) ______________

Address ______________________________
STREET APT #

____
CITY STATE ZIP

7 Patient Dental History

Child's General Dentist ______________________________

☐ Present ☐ Previous Date of last visit ____ / ____ / ____

Has your child ever had injury to his / her: ☐ Mouth ☐ Teeth ☐ Chin

Have adenoids or tonsils been removed? ☐ Y ☐ N

Does your child have any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever experienced any pain / discomfort in the jaw (TMJ / TMD)? ☐ Y ☐ N

Does your child brush his / her teeth daily? ☐ Y ☐ N

Does your child floss his / her teeth daily? ☐ Y ☐ N

Has your child ever experienced any of the following?

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

Has your child ever been evaluated for orthodontic treatment? ☐ Y ☐ N

What would you like orthodontics to accomplish? ______________________________

____

____

8 Patient Medical History

Child's Physician ______________________________

☐ Present ☐ Previous Date of last visit ____ / ____ / ____

Is your child under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

GIRLS: has menstruation begun? ☐ Y ☐ N

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has your child ever taken Phen-Fen? (Redux or Pondimin) ☐ Y ☐ N

If yes, when? ______________________________

Please list all drugs your child is currently taking ______________________________

____

Please list all drugs / things your child is allergic to ______________________________

____

Has the patient ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergies to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergy to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Artificial Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems your child has had ______________________________

____

____

Thank you for filling out this form!

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 that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

______________________________ ______________
SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit treatment frees and may, at the discretion of the office, use the services of one or more credit reporting services.

______________________________ ______________
SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

______________________________ ______________
SIGNATURE OF PARENT OR GUARDIAN DATE

The parent or guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.