WELCOME

TO THE ORTHODONTIST

Stuart A. Sheer, D.D.S. Orthodontics for Children and Adults

1 Tell Us About Your Child

Today's Date: ____/____/____ Nickname:______________________________
CHILD PREFERS TO BE CALLED

Child's Name:____
LAST FIRST MI

Birthdate: ____/____/____ Age:____________ ☐ Male ☐ Female

School:____

Hobbies / Sports: ____

Child's Home #: (_____)____

Child's Home Address: ____

____
CITY STATE ZIP

2 Who is Accompanying Your Child Today?

Name:______________________________ Relation:__________________

Do you have legal custody of this child? ______________________________

List brothers / sisters with age:______________________________

____

General Dentist:____

Last Visit Date:____

Parents Marital Status: ☐ Single ☐ Partnered ☐ Divorced
☐ Married ☐ Separated ☐ Widowed

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☐ **Mother's Information:** ☐ Step Mother ☐ Guardian

Name:______________________________ Birthdate: ____/____/____

Email Address:____

Cell #: (_____)______________________ Home #: (_____)____________

Employer:______________________ Work #: (_____)____________

SS #:______________________________

☐ **Father's Information:** ☐ Step Father ☐ Guardian

Name:______________________________ Birthdate: ____/____/____

Email Address:____

Cell #: (_____)______________________ Home #: (_____)____________

Employer:______________________ Work #: (_____)____________

SS #:______________________________

4 Financial Responsibility

Name:____

Relation:____

Address (If Different): ____

____

Home#: (_____)____

Cell#:(_____)____

5 Primary Orthodontic Insurance

Orthodontic Benefits: ☐ 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 Birthdate: ____/____/____ ID#:____________________

Policy Owner's Employer:____

Secondary Orthodontic Insurance

Orthodontic Benefits: ☐ 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 Birthdate: ____/____/____ ID#:____________________

Policy Owner's Employer:____

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What are the main concerns that you would like orthodontics to accomplish?_______________

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth, or chin? ☐ Yes ☐ No

List any musical instruments played:_______________

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any TMJ / TMD problems? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician:_______________

Phone#: (_____)_______________

Date of Last Visit:_______________

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please list all medications that your child is currently taking:_______________

____

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

____

7 Has your child ever had any of the following medical problems?

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

Please discuss any medical problems that your child has had:

____

____

____

8 Has your child ever experienced 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

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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 health.

I authorize release of any information regarding my child's orthodontic treatment to my dental and / or medical insurance company.

____

Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of servicess 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. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of parent or guardian Date

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