Welcome to Othman Orthodontics & Facial Aesthetics

Tell us about your child

Today's Date: / / Nickname:

Name:
First Middle Last

Gender: M F

Birthdate: / / Age:

School: Grade:

Hobbies / Sports:

Child's Home #: ( )

Home Address:

City State Zip

Who is accompanying your child today?

Name:

Relation:

Do you have legal custody of this child? Y N

Whom may we thank for referring you?

List other family members seen by us

Dentist Name:

Ph #: ( )

Date of last visit: / /

Parent's marital status

Single Married Divorced Widowed

Separated Partnered

Parental Information

Mother Stepmother Guardian

Name: Birthdate: / /

Wk#: ( ) Hm#: ( )

Employer:

How long at current job: Job Title:

SS#: DL#: ( )

Father Stepfather Guardian

Name: Birthdate: / /

Wk#: ( ) Hm#: ( )

Employer:

How long at current job: Job Title:

SS#: DL#: ( )

Person Responsible for Account

Name: Relation:

Billing Address:

City State Zip

HM#: Cell#: ( )

Employer:

WK#: SS#:

Who is responsible for making appointments ?

Name:
First Middle Last

Wk#: ( )

Cell#: Hm#: ( )

E-mail Address:

Orthodontics Insurance

Primary

Orthodontic Coverage? Y N

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone # : ( )

Group # (Plan, Local or Policy #):

Policy Owner's Name:

Relation: Birthdate: / /

Insured's ID:

Insured's Employer:

Employer's Address:

Secondary

Orthodontic Coverage? Y N

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone # : ( )

Group # (Plan, Local or Policy #):

Policy Owner's Name:

Relation: Birthdate: / /

Insured's ID /SS#:

Insured's Employer:

Employer's Address:

Tell us about your child

What would you like orthodontics to accomplish?

Has your 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 instrument played:

Have adenoids or tonsils been removed? ☐ Y ☐ N

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

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Y ☐ N

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

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

Child's Physician:

Ph#: ( ) 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

Please describe child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has your child ever taken Phen-Fen? ☐ Y ☐ N

(Redux or Pondimin) If yes, when?

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

Latex ☐ Y ☐ N Metals/Nickel ☐ Y ☐ N Plastics ☐ Y ☐ N

I understand that the information that I have been given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status.

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

Signature: Date: / /

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

Signature: Date: / /

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: 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.

Has your child ever had any of the following medical

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
Allergic to Latex / Metals	☐ Y ☐ N	Hearing Impairment	☐ Y ☐ N
Allergic 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)	☐ Y ☐ N

Please discuss any medical problems that your child has had:

Has your child ever experienced any of the following?

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	☐ Y ☐ N

Neighbor or Relative not living with you:

Name:

Ph #: ( )

Home Address:

City State Zip

Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials:

Date: / /

Doctor's Comments:

Signature: Date: / /