

# WELCOME

## TO JOHNSON ORTHODONTICS

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### Tell Us About Your Child

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Birthday: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Child's Age: \_\_\_\_\_  
Last First MI

Nickname: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

Email Address: \_\_\_\_\_

### Who is Accompanying the Child Today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other siblings and ages: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Parent's Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Remarried  
\_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated

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### Parent Information

\_\_\_ Mother \_\_\_ Stepmother \_\_\_ Guardian

Name: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_

OCC: \_\_\_\_\_ Length of employment: \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Cell # \_\_\_\_\_

\_\_\_ Father \_\_\_ Stepfather \_\_\_ Guardian

Name: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_

OCC: \_\_\_\_\_ Length of employment: \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Cell # \_\_\_\_\_

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### Person Responsible For Account

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

How long at this address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Previous Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

### Who Is Responsible for Making Appointments?

Name: \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Cell # \_\_\_\_\_

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### Orthodontic Insurance Coverage

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City State Zip

Ins. Phone #: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Birthday \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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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.

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## Dental History

What is the primary reason for today's visit?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the child experienced problems with previous dental work?  yes  no

Is the child's water fluoridated?  yes  no

Is the child taking fluoridated supplements?  yes  no

**Has the child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)?**  yes  no

Does the child brush his/her teeth daily?  yes  no

Floss his/her teeth daily?  yes  no

Child's Physician: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Last visit: \_\_\_\_\_

Is the child currently under the care of a physician?

**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 that cause the child allergic reactions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I affirm that the information I have given is correct to the best of my knowledge. It 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.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Medical History

**Has the child experienced the following medical problems?**

- |                              |                         |
|------------------------------|-------------------------|
| Y N Abnormal Bleeding        | Y N Hemophilia          |
| Y N AIDS                     | Y N Hepatitis           |
| Y N Anemia                   | Y N High Blood Pressure |
| Y N Any Hospital Stays       | Y N Hives               |
| Y N Any Operations           | Y N HIV+                |
| Y N Asthma                   | Y N Immunization        |
| Y N Cancer                   | Y N Kidney              |
| Y N Chicken Pox              | Y N Liver Problems      |
| Y N Congenital Heart Defects | Y N Low Blood Pressure  |
| Y N Convulsions              | Y N Measles             |
| Y N Diabetes                 | Y N Mononucleosis       |
| Y N Epilepsy                 | Y N Rheumatic Fever     |
| Y N Exposed to HIV, but neg. | Y N Scarlet Fever       |
| Y N Handicaps/Disabilities   | Y N Skin Rash           |
| Y N Hearing Impairment       | Y N Tuberculosis (TB)   |
| Y N Heart Murmur             |                         |

Would you would like to discuss anything with the Doctor in private?

yes  no

Please discuss any serious medical problems the child experiences/ed: \_\_\_\_\_

Does / did the child have any of the following habits?

- |                              |                           |
|------------------------------|---------------------------|
| Y N Lip Sucking/Biting       | Y N Tongue Thrust         |
| Y N Nail Biting              | Y N Thumb/Finger Sucking  |
| Y N Chewing on Objects       | Y N Tongue/Cheek Biting   |
| Y N Mouth Breather           | Y N Speech Problems       |
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Used Pacifier            | Y N Breast Fed            |

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

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

## Thank you for filling out this form completely.

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

**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.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Office Use Only

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein. Initials: \_\_\_\_\_  
Doctor's comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History Update

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Comments: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Comments: \_\_\_\_\_