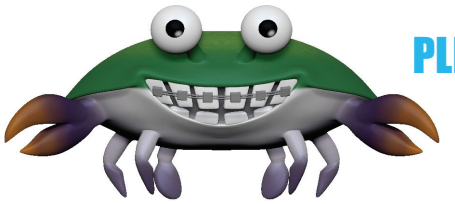
Welcome to our practice!



PLEASE FILL OUT ALL THREE PAGES

Today's Date:_____

Child's Name:_____Nickname:_____
LAST, FIRST MI

Birthday:____/_____/_____ Gender: ☐ M ☐ F Age:_____

Child's Home Address: _____

Child's Home #: (_____)_____ Preferred Email:_____

School: _____ Grade: _____ Hobbies/Sports: _____

Siblings Names & Ages: _____

General Dentist _____ Last Dental Visit: _____

Who may we thank for referring you? _____

Who is accompanying patient today: _____ Relation: _____

Parent/Guardian Information:

Guardian/Guarantor Name:_____Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email _____

Employer: _____Occupation: _____Work # _____

Guardian/Guarantor Name: _____ Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email_____

Employer: _____ Occupation: _____Work # _____

Insurance Information:

Orthodontic Coverage ☐ Yes ☐ No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Secondary Orthodontic Coverage ☐ Yes ☐ No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Person(s) Responsible for paying account: _____ **Relation:**_____

Address (if different than above)_____

Medical History

Is your child currently taking medications? ☐ Yes ☐ No

If so, please list here:_____

Is your child **allergic** to any medications or dental products? ☐ Yes ☐ No

If so, please list here: _____

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

Physician's Name: _____ Phone _____

Has your child begun puberty? ☐ Yes ☐ No (this question tells us about your child's growth)
(Girls) Has your child begun menstruation? ☐ Yes ☐ No
(Girls) Is your child currently pregnant? ☐ Yes ☐ No

Please list any serious medical condition(s) that your child has or has ever had:

_____

_____

Have you/your child experienced any of the following:

☐ Yes ☐ No Abnormal bleeding
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No ADD/ADHD
☐ Yes ☐ No Heart Surgery/Pacemaker
☐ Yes ☐ No AIDS/HIV+
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Any hospital stay/operations
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Herpes/Fever blisters
☐ Yes ☐ No Artificial bones/joints/valve
☐ Yes ☐ No High/Low blood pressure
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No Cancer
☐ Yes ☐ No Liver problems
☐ Yes ☐ No Congenital heart defect
☐ Yes ☐ No Mitral valve prolapse

☐ Yes ☐ No Convulsions
☐ Yes ☐ No Prosthetics
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Frequent headaches
☐ Yes ☐ No Seizures/Fainting
☐ Yes ☐ No Handicaps/Disabilities
☐ Yes ☐ No Shingles
☐ Yes ☐ No Hay fever
☐ Yes ☐ No Sickle cell disease/traits
☐ Yes ☐ No Hearing impairment
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Heart attack/Stroke
☐ Yes ☐ No Venereal disease
☐ Yes ☐ No Allergies to Latex

Other (please specify): _____

Does your child have allergies to any of the following:

☐ Yes ☐ No Local anesthetics
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Ibuprofen
☐ Yes ☐ No Sulfa Drugs
☐ Yes ☐ No Food (specify):

☐ Yes ☐ No Vinyl
☐ Yes ☐ No Metals
☐ Yes ☐ No Codeine or other narcotics
☐ Yes ☐ No Acrylic
☐ Yes ☐ No Animals

Other (specify): _____

Dental History

☐ Yes ☐ No	Has your child ever been evaluated or had orthodontic treatment before?
☐ Yes ☐ No	Has your child seen a general dentist in the last 6 months?
☐ Yes ☐ No	Have there been any injuries to the face, mouth, teeth or chin?
☐ Yes ☐ No	Does your child require antibiotics before dental treatment?
☐ Yes ☐ No	Have adenoids or tonsils been removed?
☐ Yes ☐ No	Has your child ever had difficulties associated with previous dental work?
☐ Yes ☐ No	Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?
☐ Yes ☐ No	Does your child brush and floss his/her teeth daily?
☐ Yes ☐ No	Are you aware of any "gum" problems?
☐ Yes ☐ No	Does your child have any of the following habits? (If so, please circle)
☐ Yes ☐ No	Clenching/Grinding teeth or nail biting or thumb/finger sucking
☐ Yes ☐ No	Lip sucking/biting or tongue thrust or mouth breather

Why have you brought your son/daughter to Dr. Koterwas today? i.e. crowding, overbite, etc...

Please Initial the Following & Sign

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

_____ I authorize Dr. Koterwas Orthodontics to communitate with my general dentist and/or other healthcare providers involved in the treatment of my child. This includes x-rays, medical record information or any relevant documentation deemed necessary to render treatment and coordinate care for the patient.

_____ I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ I hereby authorize Dr. Koterwas Orthodontics, DDS, LLC and/or Koterwas Orthodontics of Prince Frederick to release all information necessary to secure the payment of benefits. I also assign, directly to the doctor, all insurance benefits otherwise payable to me.

Signature of Parent or Guardian Date