Welcome to our office!

We look forward to getting to know you and your child!

olentangy Orthodontics

Today's Date _____

About Your Child

Child's Name _____ Nickname/Preferred Name _____
Last First MI

Birthdate _____ Age _____ ☐ Male ☐ Female _____

General Dentist _____ Last Visit Date _____

Home Ph _____ Hobbies, Sports, Interests _____

Child's Home Address _____
Street

_____
City State Zip

List brothers/sisters with age _____

Who may we thank for referring you to our office? _____

Child's Parents

Parents' Relationship Status ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Mother's Information ☐ Step Mother ☐ Guardian

Name _____ Birthdate _____

Email Address _____

Cell Ph _____ Home Ph _____

Employer _____

SSN# _____

Work Ph _____ Ext _____

Home Address (if different from patient)

_____
Street

_____
City State Zip

☐ Father's Information ☐ Step Father ☐ Guardian

Name _____ Birthdate _____

Email Address _____

Cell Ph _____ Home Ph _____

Employer _____

SSN# _____

Work Ph _____ Ext _____

Home Address (if different from patient)

_____
Street

_____
City State Zip

Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Please provide a copy of your insurance card/coverage to us.

Office Use Only

Lifetime Max _____

Pays at % _____

Deductible _____

Amount used to date _____

Monthly/Quarterly/Other _____

% Initial Placement _____

Automatic ☐ Yes ☐ No

Emergency Contact

Name _____ Phone _____

Payment of Services

Payment is due in full at time of treatment unless prior arrangements have been approved.
If this office accepts my insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Dr. Edith Kang. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

_____ _____
Signature Date

Continue to other side →

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About Your Child's Health

How would you describe your child's health? ☐ Good ☐ Fair ☐ Poor

Child's Physician _____ Phone _____ Date of Last Visit _____

Is your child currently being treated by a physician? Yes No Reason _____

Has puberty begun? Yes No Has menstruation begun? (Girls) Yes No

Please list all drugs/medications your child is currently taking (including over the counter) _____

_____

Does your child have any allergies to foods and/or drugs/medications? Yes No

Please list _____

Allergy to Latex Yes No Metals/Nickel Yes No Plastics Yes No

Please tell us if your child has had any of the following (past and present)?

Y	N	Abnormal Bleeding	Y	N	Convulsions/Epilepsy	Y	N	ADD/ADHD
Y	N	Diabetes	Y	N	Radiation Therapy	Y	N	Handicaps/Disabilities
Y	N	Bisphosphonate Therapy	Y	N	Hearing Impairment	Y	N	Birth Defects/Hereditary Problems
Y	N	Heart Murmur	Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis	Y	N	Artificial Bones/Joints/Valves
Y	N	HIV+/AIDS	Y	N	Asthma	Y	N	Lupus
Y	N	Rheumatic/Scarlet Fever	Y	N	Cancer	Y	N	Congenital Heart Defect
Y	N	Tuberculosis	Y	N	Delayed Growth	Y	N	Other(Please explain below)

Please explain any "Y/Yes" answers _____

_____

Orthodontic/Dental Concerns

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

Please explain your reason/concern for an orthodontic evaluation of your child _____

Has your child had any injuries to the face, mouth, teeth or chin? Yes No

Have you been informed of any missing or extra permanent teeth in your child's mouth? Yes No

Has your child ever had pain/tenderness/discomfort in their jaw joint (TMJ/TMD)? Yes No

How often does your child brush his/her teeth in a day? ____

Does your child floss his/her teeth daily? Yes No

Please list any musical instruments your child plays _____

_____

Is your child self conscious or sensitive about their teeth? Yes No

Do you wish to address/discuss any issues regarding your child privately (in the absence of your child)? Yes No

Comments: _____

_____

Does your child have a history of any of the following (past and present)

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

Have they stopped their thumb/finger sucking? Yes No

If Yes what age _____

If No do they want to stop but are having difficulty? Yes No

Sign Here

I have read and understand that the information that I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's medical health status. I will not hold my orthodontist or any member of the office staff responsible for any errors or omissions that I have made in completion of this form. I authorize the office staff to perform the necessary dental services my child may need.

_____ _____

Signature of parent or guardian Date

Office Use Only

Doctor's Review Signature: _____ Date: _____

Doctor's Comments: _____

_____

_____

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