KIDS ARE GREAT
Dental Associates

WELCOME TO THE ORTHODONTIST

Today's Date ___/___/___

Child's Name: _____

Nickname: _____ Male _____ Female _____

Child's Birthdate: ___/___/___ Age: _____

School: _____

Hobbies / Sports: _____

Child's Home #: _____

Child's Home Address: _____

Who is accompanying your child today? _____

Name: _____ Relation: _____

Do you have legal custody? Y ___ N ___

Whom may we thank for referring you? _____

List brothers / sisters and age: _____

Patient's Dentist_____ Phone # _____

Last Visit Date: ___/___/___

Parent I Information ___ Guardian

Name: _____ Birthdate: ___/___/___

Employer: _____

Cell #: _____ Home #: _____

Email: _____

Social Security #: _____ - _____- _____ Insurance carrier _____

Parent 2 Information ___ Guardian

Name: _____ Birthdate: ___/___/___

Employer: _____

Cell #: _____ Home # _____

Social Security #: _____ - _____ - _____ Insurance carrier_____

Email: _____

What are the main concerns that you would 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 instruments 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

Child's Physician _____Date of Last Visit ___/___/___

Is your child currently under the care of a physician?___Y___N

Has puberty begun?___Y___N

Has menstruation begun? (Girls)___Y___N

Please describe your child's current health __Good ___Fair ___Poor

Please list all drugs that your child is currently taking_____

Please list all drugs that your child is allergic to_____

Growth Hormone _____Y _____No

Has your child ever had any of the following problems?

Allergies to any Drugs___Y___N

Allergic to Latex/Metals__Y__N

Allergic to Plastics__Y___N

Any Hospital Stays__Y__N

Any Operations__Y__N

Asthma___Y___N

Cancer___Y___N

Congenital Heart Defect__Y___N

Convulsions/Epilepsy__Y__N

Diabetes__Y__N

Handicaps/Disabilities__Y__N

Hearing Impairment___Y___N

Heart Murmur__Y__N

Hemophilia__Y__N

Hepatitis__Y__N

HIV + / Aids__Y__N

Kidney/Liver problems__Y__N

Rheumatic/Scarlet Fever__Y__N

Tuberculosis__Y__N

Abnormal Bleeding__Y__N

Please discuss any medical problems that your child has_____

Does your child have any of the following habits?

Clenching/Grinding Teeth__Y__N Lip Sucking/Biting__Y__N

Mouth Breather__Y__N Nursing Bottle Habits__Y__N

Nail Biting__Y__N Speech Problems__Y__N

Thumb/Finger Sucking Habits__Y__N Tongue Thrust__Y__N

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

Signature of parent or guardian _____Date_____

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize <Kids Are Great Dental> to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and other involved in my treatment, payment for my treatment, or <Kids Are Great Dental> health care operations. The patient information that may be emailed may include x-rays, health history, and diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, <Kids Are Great Dental> may use other ways to send my information, U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re disclosed and no longer protected by privacy law.
- <Kids Are Great Dental> does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that <Kids Are Great Dental> already sent before receiving my written instructions to stop.

Patient Name (Please print):

_____

_____

Signature: _____

Date: _____