

OXMOOR VALLEY ORTHODONTICS

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SPECIALIST IN ORTHODONTICS

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ Male Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: _____

Child's Home Address: _____
APT/CONDO #

CITY STATE ZIP

Email Address: _____
(FOR APPOINTMENT REMINDERS & NEWSLETTERS)

General Dentist: _____

Last Visit Date: _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

List brother/sisters with age: _____

Parent's Marital Status: Single Married
 Widowed Divorced Separated

3 Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding	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 Asthma	Y N HIV+ / AIDS
Y N Cancer	Y N Kidney/Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic/Scarlet Fever
Y N Convulsions/Epilepsy	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

4 What are the main concerns that you would like orthodontics to accomplish?

Chief Concern: _____

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

Have there been any injuries to the face mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD) Yes No

Popping or clicking in jaw joints? Yes No

Jaws tire during meals? Yes No

Tightness in joints? Yes No

Headaches? Daily Weekly Monthly

Does your child brush his/her teeth adequately? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit _____

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

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

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

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

5 Does your child have any of the following habits?

Y N 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

CONTINUED ON BACK

Member
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General Information

Mother's Information: Step Mother Guardian
 Email Address: _____
(FOR APPOINTMENT REMINDERS & NEWSLETTERS)
 Name: _____ Birthdate: ___/___/___
 Wk#: _____ Ext: _____ Hm#: _____
 Employer: _____
 How Long at Current Job: _____ Job Title: _____
 SS#: _____ DL#: _____
 Father's Information: Step Father Guardian
 Email Address: _____
(FOR APPOINTMENT REMINDERS & NEWSLETTERS)
 Name: _____ Birthdate: ___/___/___
 Wk#: _____ Ext: _____ Hm#: _____
 Employer: _____
 How Long at Current Job: _____ Job Title: _____
 SS#: _____ DL#: _____

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Legal Guardian Information

Name: _____ Relation: _____
 Billing Address: _____

 CITY STATE ZIP
 Previous Address: _____

 CITY STATE ZIP
 Wk#: _____ Ext: _____ Hm#: _____
 Email Address: _____
 Employer: _____
 SS#: _____ DL#: _____
 Who is responsible for making appointments?
 Name: _____
 Wk#: _____ Ext: _____ Hm#: _____

Since we are here throughout the day, and in order to keep our schedule even through the day, will you accept in school / work appointments?
 Yes No

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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 changes in my child's medical status.
 This office reserves the right to verify the credit status of potential patients and/or parents of patients.

Signature of parent or guardian _____ Date _____
 Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

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Primary Orthodontic Insurance

Orthodontic Coverage? Yes No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone: _____
 Group # (Plan, Local, or Policy#): _____
Policy Owner's Name: _____
 Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___ **SS#:** _____
Policy Owner's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone: _____
 Group # (Plan, Local, or Policy#): _____
Policy Owner's Name: _____
 Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___ **SS#:** _____
Policy Owner's Employer: _____

In the event of an emergency, is there someone who lives near you that we could contact?

His/Her Name: _____
 Relation: _____
 Wk#: _____ Hm#: _____

Nearest Relative: _____
 Relation: _____
 Address: _____
 Wk#: _____ Hm#: _____

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 I hereby grant permission for the use of these photographs to Dr. Sema for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

X _____ Date _____ X _____
 Patient Signature Parent/Guardian if under 18 years old