Welcome to altschul 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. Please fill out the requested information below completely:

Today's Date: _____ Sex: ☐ M ☐ F Child's Name: _____

Email: _____ Child's Nickname: _____

Other family members seen by us: _____

Your Child's Physical Health History

General Dentist's Name: _____

Phone: _____ Date of Last Visit: _____

Has your child ever taken Phen-Fen? (Also known as Redux or Pondimin) If yes, when? _____ ☐ Yes ☐ No

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

Does your child brush his / her teeth daily? ☐ 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 / things that your child is allergic to: _____

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

☐ Yes ☐ No	Abnormal Bleeding	☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	ADD / ADHD	☐ Yes ☐ No	Handicaps / Disabilities
☐ Yes ☐ No	Allergic to Any Drugs	☐ Yes ☐ No	Hearing Impairment
☐ Yes ☐ No	Allergic to Latex / Metals	☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Allergic to Plastic	☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Any Hospital Stays	☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Any Operations	☐ Yes ☐ No	HIV+ / AIDS
☐ Yes ☐ No	Artificial Bones / Joints / Valves	☐ Yes ☐ No	Kidney / Liver Problems
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Lupus
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Rheumatic / Scarlet Fever
☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No	Tuberculosis (TB)
☐ Yes ☐ No	Convulsion / Epilepsy		

Please discuss any medical problems that your child has had: _____

Your Child's Dental Health History

Has your child ever experienced any of the following?

☐ Yes ☐ No	Clenching / Grinding Teeth	☐ Yes ☐ No	Speech Problems
☐ Yes ☐ No	Lip Sucking / Biting	☐ Yes ☐ No	Any Operations
☐ Yes ☐ No	Mouth Breathing	☐ Yes ☐ No	Thumb / Finger Sucking
☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No	Tongue Thrust
☐ Yes ☐ No	Nursing Bottle Habits		

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

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Brownsburg, IN 46112
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Date_____

Confidential Responsible Party Information

A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address____ Home Phone_____ Work Phone_____ Cell Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

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

Insurance Information

Policy Holder's Name_____ and Soc.Sec. # _____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I authorize the dental staff to perform the necessary dental services required. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____