

Welcome to Dr. Pearson's Office!

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.

Tell Us About Your Child

Today's date: _____ Nickname: _____

Child's Name: (Last, first, middle) _____

Email address: _____ SS #: _____

Birthdate: _____ Age: _____ Circle one: Male Female

School: _____ Grade _____

Hobbies/Sports: _____

Child's home phone #: _____

Child's home address: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Circle one: Yes No

Whom may we thank for referring you? _____

List brothers/sisters with age: _____

General dentist: _____

Last visit date: _____

Parents' marital status: Circle one: Single Married Divorced Widowed Separated

Mother's Information Circle One: Step mother Guardian

Name: (Last, first, middle) _____ Birthdate: _____

Work phone #: _____ Home phone #: _____

Employer: _____

How long there? _____ Job Title: _____

SS #: _____ DL #: _____

Father's Information Circle One: Step father Guardian

Name: (Last, first, middle) _____ Birthdate: _____

Work phone #: _____ Home phone #: _____

Employer: _____

How long there? _____ Job Title: _____

SS #: _____ DL #: _____

Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

Previous Address: _____

Home phone #: _____ DL #: _____

Employer: _____

Work phone #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Work phone #: _____ Home phone #: _____

Primary Orthodontic Insurance

Orthodontic Coverage: (circle one) Yes No

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Policy owner's name: _____

Relation to patient: _____

Policy owner's birthdate: _____ Insured's SS#: _____

Policy owner's employer: _____

Employer's address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage: ç

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Policy owner's name: _____

Relation to patient: _____

Policy owner's birthdate: _____ Insured's SS#: _____

Policy owner's employer: _____

Employer's address: _____

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

Has your child ever taken Phen-Fen (Also known as Redux or Pondimin) (circle one) Yes No

If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? (circle one) Yes No

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? (circle one) Yes No

Has you child been informed of any missing or extra permanent teeth? (circle one) Yes No

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

Does you child brush his/her teeth daily? (circle one) Yes No

Floss his/her teeth daily? (circle one) Yes No

Child's physician: _____

Phone #: _____ Date of last visit: _____

Is your child currently under the care of a physician? (circle one) Yes No

Has puberty begun? (circle one) Yes No

(Girls) Has menstruation begun? (circle one) Yes No

Please describe your child's current physical health: (circle one) 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? (Please circle all that apply)

- | | |
|--------------------------------|-------------------------|
| Abnormal Bleeding | Convulsions/Epilepsy |
| ADD/ADHD | Diabetes |
| Allergies to any Drugs | Handicaps/Disabilities |
| Allergic to Latex/Metals | Hearing Impairment |
| Any Hospital Stays | Hemophilia |
| Any Operations | Hepatitis |
| Artificial Bones/Joints/Valves | HIV+/AIDS |
| Asthma | Kidney/Liver Problems |
| Cancer | Rheumatic/Scarlet Fever |
| Congenital Heart Disease | Turberculosis (TB) |

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

Has your child ever had any of the following medical problems? (Please circle all that apply)

- | | |
|--------------------------|-----------------------|
| Clenching/Grinding Teeth | Nursing Bottle Habits |
| Lip Sucking/Biting | Speech Problems |
| Mouth Breather | Thumb/Finger Sucking |
| Nail Biting | Tongue Thrust |

Neighbor or relative not living with you.

Name _____ Phone# _____

Address _____

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.

Signature of parent or guardian

Date

This office reserves the right to verify the credit status of potential patients and /or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of parent or guardian

Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature

Date

**The parent or guardian who accompanies the child is responsible for payment.
Our office HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

