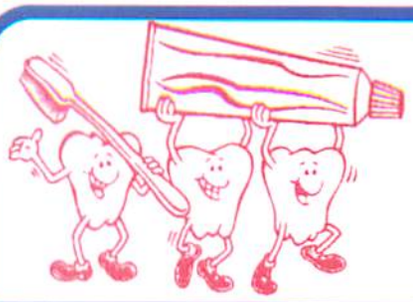

# WELCOME

TO

## Your Neighborhood Orthodontist

LARRY KAWA, D.D.S.
ALEX BARBOSA, D.D.S.
SCOTT SPENCER, D.M.D.

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: _____

Home # _____ Email: _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

## 2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Parent's Marital Status: ○ Single ○ Widowed ○ Seperated ○ Married ○ Divorced

Whom may we Thank for referring you? _____

General Dentist: _____

Brothers or Sisters: Birthdate:

_____ / /

_____ / /

_____ / /

Do they live with you? ○ Yes ○ No

## 3

Mother's Information: ○ Step Mother ○ Guardian

Name: _____ Birthdate: / /

Wk # _____ Ext: _____ Hm#: _____

Cell # _____ Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL#: _____

Father's Information: ○ Step Father ○ Guardian

Name: _____ Birthdate: / /

Wk # _____ Ext: _____ Hm#: _____

Cell # _____ Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL#: _____

## 4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Previous Address: _____

_____
City State Zip

Wk# _____ Ext: _____ Hm#: _____

Employer: _____

DL#: _____ SS#: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____

Wk#: _____ Ext: _____ Hm#: _____

## 5 Primary Orthodontic Insurance

hodontic Coverage?

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: _____

CONTINUED ON BACK

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

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 care of a phyician? ○ 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: _____

## 7 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: _____

## 8 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 |

## 9 Do you know of any other family member or friend who would benefit from orthodontic treatment? ○ Yes ○ No

Name _____ Home Phone _____

Name _____ Home Phone _____

Name _____ Home Phone _____

## 10

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 to my child's medical status.

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 this office, use the services of one or more credit reporting services.

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

_____
Signature of parent or guardian date

_____
Signature of parent or guardian date

The Parent or Guardian who accompanies the child is responsible for payment.

Our office 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: _____

Doctors Comments: