Welcome

1 About Your Teen

Today's Date: ____/____/____ File #: ________

Teen's Name: ________ LAST ________ FIRST ________ M.I.

Teen's Nickname: ________ ❑ Boy ❑ Girl

Teen's Birthdate: ____/____/____ Age: ________

School: ________ Grade: ______

Teen's Home Phone #:(______) ________

Teen's SS#: ________

Teen's Address: ________ HOME ADDRESS

________ CITY ________ STATE ________ ZIP

Referred By: ________
(If doctor, please give address & phone number.)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: ________

Address: ________

________ CITY ________ STATE ________ ZIP

Phone #: ________

Insured's ID#: ________

Group # (Plan, Local, or Policy #): ________

Insured's Name: ________

Relation: ________ Date of Birth: ___/___/___

Insured's Employer: ________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ________

Address: ________

________ CITY ________ STATE ________ ZIP

Phone #: ________

Insured's ID#: ________

Group # (Plan, Local, or Policy #): ________

Insured's Name: ________

Relation: ________ Date of Birth: ___/___/___

Insured's Employer: ________

3 Teen's Family Information

Who is accompanying this teen today?

________ FULL NAME (IF OTHER THAN PARENT) ________ RELATION TO TEEN

Do you have Legal Custody of this Teen? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): _____ _____ _____

Mother's Name: ________ ❑ STEP MOTHER ❑ GUARDIAN

________ (❑ **CHECK IF SAME AS TEEN'S**) HOME ADDRESS ________ CITY ________ STATE ________ ZIP

(______)________ HOME PHONE # (______)________ WORK PHONE # ________ EXT.

________ MOTHER'S SOCIAL SECURITY # ___/___/___ DATE OF BIRTH ________ MOTHER'S DRIVERS LIC. #

Employer: ________ How Long? ______

________ EMPLOYER'S ADDRESS ________ CITY ________ STATE ________ ZIP

Father's Name: ________ ❑ STEP FATHER ❑ GUARDIAN

________ (❑ **CHECK IF SAME AS TEEN'S**) HOME ADDRESS ________ CITY ________ STATE ________ ZIP

(______)________ HOME PHONE # (______)________ WORK PHONE # ________ EXT.

________ FATHER'S SOCIAL SECURITY # ___/___/___ DATE OF BIRTH ________ FATHER'S DRIVERS LIC. #

Employer: ________ How Long? ______

________ EMPLOYER'S ADDRESS ________ CITY ________ STATE ________ ZIP

4 Account Information

Person ultimately responsible for account

Name: ________ ________ RELATION TO TEEN

Billing Address: ________

________ CITY ________ STATE ________ ZIP

________ SOCIAL SECURITY # ___/___/___ DATE OF BIRTH ________ DRIVERS LIC. #

(______)________ WORK PHONE #: ________ EXT. (______)________ CELL PHONE #:

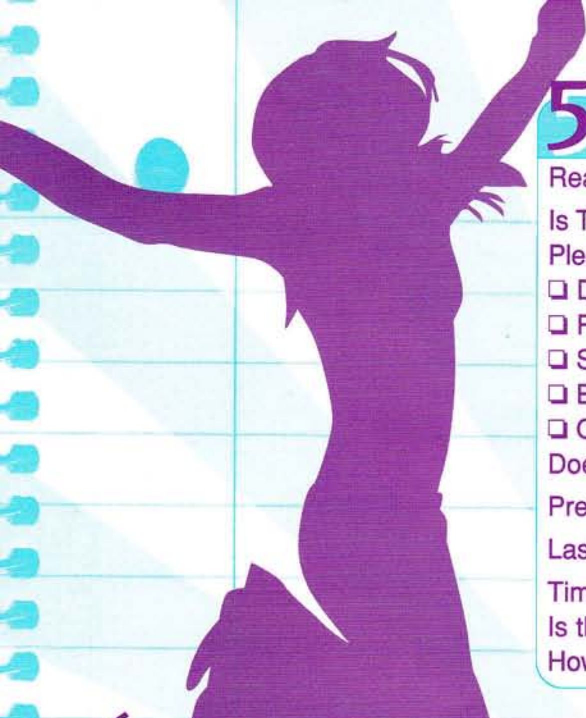
Payment method: ❑ Cash ❑ Check

________ ____/____

❑ Credit Card - Enter card # above (if accepted)

________ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back



5 Teen's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Teen in pain? ❑ No ❑ Yes How Long? ____________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s): ____________

Does teen require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________ (____) ____________

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day teen brushes? ______ Times a week teen flosses? ______

Is the teen's water fluoridated? ❑ Yes ❑ No

How would you rate the teen's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Teen's Medical History

Is Teen taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others: ____________

Teen's Physician: ____________ (____) ____________
DOCTOR'S NAME OR CLINIC NAME — PHONE#

____________ Last Medical Exam: ___/___/___
ADDRESS CITY STATE ZIP

Does Teen have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** Chicken Pox
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia/Abnormal Bleeding	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** High/Low Blood Pressure	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

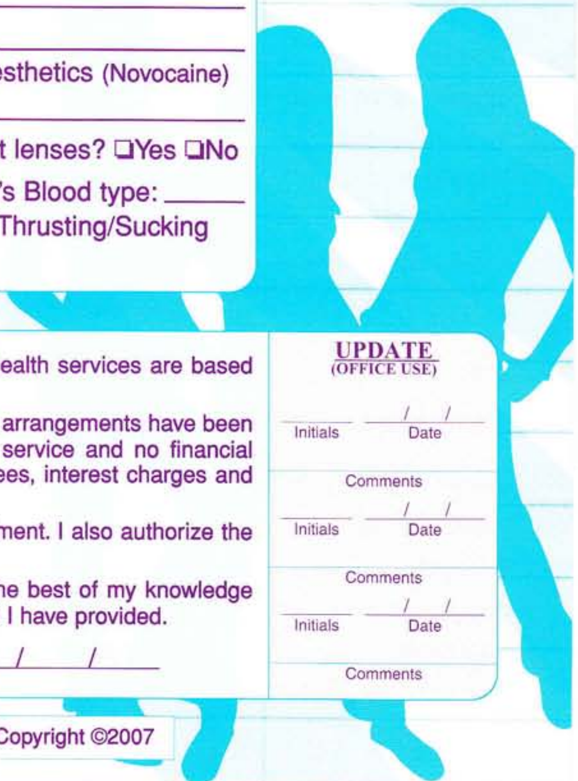
Please list any other medical condition(s) teen has or ever had: ____________

Is Teen allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s): ____________

Please rate the teen's general health from 1-10: ______ Does teen wear contact lenses? ❑Yes ❑No

Has this teen ever taken the drug Ritalin? ❑ No ❑ Yes/How long? ______ Teen's Blood type: ______

Does this teen do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting



- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____________ Date ___/___/___
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

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