



WELCOME



TO DJM ORTHODONTICS!

DAVID J MYERS,
DDS, MS

Please fill out this form completely. The better we communicate, the better we can care for you!

★ TELL US ABOUT YOUR CHILD

Today's Date: ___/___/___ Nickname: _____

CHILD'S NAME: _____

Child's Birthdate: ___/___/___ Child's Age: _____ Male Female

E-mail Address: _____

School: _____ Grade: _____

Hobbies/sports: _____

Childs Home #: () _____ SS# _____

Childs Home Address: _____

CITY

STATE

ZIP

★ GENERAL INFORMATION

Who is accompanying the child today? _____

Name: _____ Relation: _____

Do you have legal custody of this child? _____ Yes No

Whom may we Thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____ Last Visit Date: _____

Dentist's Phone: () _____

Relative or Friend not living with you:

Name: _____ Phone: () _____

Address: _____

CITY

STATE

ZIP

★ PARENT'S INFORMATION ★

Who is responsible for account? _____ Parent's Marital Status: Single Married Partnered Widowed Divorced Separated

FATHER Step Father Guardian

Name: _____ Birthdate ___/___/___

Address: (If different than Child's) Hm #: () _____

SS# _____ DL# _____

Wk#() _____ Ext: _____ Cell/Other # _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

CITY

STATE

ZIP

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

CITY

STATE

ZIP

Insurance Phone: () _____ Insured's ID# _____

Group # (Plan, Local, or Policy #) _____

MOTHER Step Mother Guardian

Name: _____ Birthdate ___/___/___

Address: (If different than Child's) Hm #: () _____

SS# _____ DL# _____

Wk# _____ Ext: _____ Cell/Other # () _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

CITY

STATE

ZIP

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

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Group # (Plan, Local, or Policy #) _____

★ AUTHORIZATION ★

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. 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

SIGNATURE OF PARENT OR GAURDIAN

DATE

★★★ DENTAL & MEDICAL HISTORY ★★★

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

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

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

Does the child require antibiotics before dental treatment? Yes No

Have adenoids or tonsils been removed? Yes No

Does your child have any missing or extra permanent teeth? Yes No

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

Does the child brush his or her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician?

Has puberty begun? Yes No

Has menstruation begun? Yes No

Please describe the child's current physical health

Good Fair Poor

Please list all drugs that the child is currently taking:

Aside from items listed below, list all drugs/things your child is allergic to:

Latex Nickel/Metals Plastic

HAS THE CHILD EXPERIENCED THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV+ | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays/Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Prosthetics |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease/Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Has the child ever taken any diet pills such as Phen-Fen? Yes No

(also known as Redux or Pondimin.) If so, when? _____

Are the child's immunizations current? Yes No

Anything you would like to discuss with the doctor in private? Yes No

Please discuss any serious medical problems the child has had:

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Breast Fed | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Used Pacifier |

List any musical instruments played: _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that this it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian _____ Date _____

★ OFFICE USE ONLY ★ OFFICE USE ONLY ★ OFFICE USE ONLY ★ OFFICE USE ONLY ★

I verbally received the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist _____ Date _____

Dentist's Comments: _____

★ MEDICAL HISTORY UPDATE ★

Has there been any change in your child's health status since their last visit? Yes No

If yes please explain. _____

PARENT/GUARDIAN SIGNATURE DATE

DENTIST SIGNATURE DATE

Has there been any change in your child's health status since their last visit? Yes No

If yes please explain. _____

PARENT/GUARDIAN SIGNATURE DATE

DENTIST SIGNATURE DATE