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: _____

APT/CONDO#

_____

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:

Insurance Co. Name: _____

Insurance Address: _____

_____

CITY STATE ZIP

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

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:

_____

_____

Y N Latex **Y N** Nickel/Metals **Y N** Plastic

HAS THE CHILD EXPERIENCED THE FOLLOWING MEDICAL PROBLEMS?

Y N	Abnormal Bleeding	**Y N**	Hearing Impairment
Y N	ADD/ADHD	**Y N**	Heart Murmur
Y N	AIDS/HIV+	**Y N**	Hemophilia
Y N	Any Hospital Stays/Operations	**Y N**	Hepatitis
Y N	Artificial Bones/Joints/Valves	**Y N**	Kidney Problems
Y N	Asthma	**Y N**	Liver Problems
Y N	Cancer	**Y N**	Mitral Valve Prolapse
Y N	Congenital Heart Defect	**Y N**	Prosthetics
Y N	Convulsions	**Y N**	Rheumatic Fever
Y N	Diabetes	**Y N**	Scarlet Fever
Y N	Epilepsy	**Y N**	Sickle Cell Disease/Traits
Y N	Handicaps/Disabilities	**Y 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?

Y N	Breast Fed	**Y N**	Nursing Bottle Habits
Y N	Clenching/Grinding Teeth	**Y N**	Speech Problems
Y N	Lip Sucking/Biting	**Y N**	Thumb/Finger Sucking
Y N	Mouth Breather	**Y N**	Tongue Thrust
Y N	Nail Biting	**Y 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

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