About Your Child

Today's Date: ________________ File #: __________

Child's Name: ____________________________________
LAST FIRST MI

Child's Nickname: _________________________________

☐ Boy ☐ Girl

School: ______________________ Grade: _______

DOB: _____________ Age: ____ SS#:________________

Home Phone: ( ) _________________________

Mailing Address: _________________________________

____
CITY STATE ZIP

Referred By: ____________________________________

Insurance Information

Primary Dental Insurance

Co. Name: ___________________________________

Address: ______________________________________

____
CITY STATE ZIP

Phone: ( ) _____________________________

Insured's ID#: __________________________________

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

Insured's Name: ________________________________

Relation: _________________ DOB: _______________

Insured's Employer: ______________________________

Secondary Insurance

Co. Name: ___________________________________

Address: ______________________________________

____
CITY STATE ZIP

Phone: ( ) _____________________________

Insured's ID#: __________________________________

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

Insured's Name: ________________________________

Relation: _________________ DOB: _______________

Insured's Employer: ______________________________

Child's Family Information

Who is accompanying this child today?

_________________________________ _______________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

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

How many siblings? ______ Age(s): ___ ___ ___ ___ ___

Mother's Name: _________________________________

☐ STEP MOTHER ☐ GUARDIAN

Mailing Address: _________________________________

____
CITY STATE ZIP

☐ CHECK IF SAME AS CHILD'S

SS#: ____

Email Address: ___________________________________

Home Phone: ( ) _________________________

Cell Phone: ( ) __________________________

Work Phone: ( ) ____________________ Ext: _____

Employer: ______________________ How long? _______

Employer's Address: ______________________________

____
CITY STATE ZIP

Father's Name: _________________________________

☐ STEP FATHER ☐ GUARDIAN

Mailing Address: _________________________________

____
CITY STATE ZIP

☐ CHECK IF SAME AS CHILD'S

SS#: ____

Email Address: ___________________________________

Cell Phone: ( ) __________________________

Home Phone: ( ) _________________________

Work Phone: ( ) ____________________ Ext: _____

Employer: ______________________ How long? _______

Employer's Address: ______________________________

____
CITY STATE ZIP

Account Information

Name: ____

Relation: ____

Billing Address: ___________________________________

____
CITY STATE ZIP

SS#: ____

Drivers License #: _________________________________

Email Address: ___________________________________

Cell Phone: ( ) __________________________

Work Phone: ( ) ____________________ Ext: _____

____
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

REFERRAL SOURCE

Whom may we thank for referring you? ☐ Dentist ☐ Patient ☐ TV Commercial ☐ Internet Search ☐ Insurance ☐ Radio ☐ Yellow Pages ☐ Sports ☐ Other (specify) ______________________________

Name of Referrer: ____________________

DENTAL/MEDICAL HISTORY

What is your main reason for visiting the orthodontist today? ____________________

General Dentist: ____________________ Phone: ____________________

Address: ____________________ Last Visit: ____________________

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a week do you floss? ______ How many times a day do you brush? ______

Physician Name: ____________________ Phone: ____________________ Last Visit: ____________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription drugs? ☐ Yes ☐ No Drug and Dose: ____________________

Are you currently under the care of a doctor? ☐ Yes ☐ No Explain: ____________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	**N**	Prosthesis	**Y**	**N**	Tuberculosis	**Y**	**N**	Convulsions/Epilepsy	**Y**	**N**	Severe/Freq Headaches
Y	**N**	Heart Attack	**Y**	**N**	Shingles	**Y**	**N**	Abnormal Bleeding	**Y**	**N**	Hi/Lo Blood Pressure
Y	**N**	Cancer	**Y**	**N**	Fever Blister	**Y**	**N**	Artificial Valves	**Y**	**N**	Drug/Alcohol Abuse
Y	**N**	Diabetes	**Y**	**N**	Scarlet Fever	**Y**	**N**	Heart Surgery/Pacemaker	**Y**	**N**	Blood Transfusion
Y	**N**	Rheumatic Fever	**Y**	**N**	Ulcers/Colitis	**Y**	**N**	Any Stays in Hospital	**Y**	**N**	Anemia/Radiation Therapy
Y	**N**	HIV+/AIDS	**Y**	**N**	Heart Murmur	**Y**	**N**	Kidney/Liver Problems	**Y**	**N**	Glaucoma
Y	**N**	Hemophilia	**Y**	**N**	Emphysema	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Difficulty Breathing?
Y	**N**	Asthma	**Y**	**N**	Sinus Problems	**Y**	**N**	Artificial Bones/Joints	**Y**	**N**	Other: ______________
Y	**N**	Hepatitis	**Y**	**N**	Congenital Heart Defect						

Are you allergic to any of the following?:

Y	**N**	Aspirin	**Y**	**N**	Dental Anesthetics	**Y**	**N**	Tetracycline	**Y**	**N**	Other: ______________
Y	**N**	Antibiotics	**Y**	**N**	Latex	**Y**	**N**	Penicillin	**Y**	**N**	**Women Only:** Are you pregnant?

CONSENT TO X-RAYS AND EXAMS

It is necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis. Your signature below authorizes Pavlik Orthodontics to take these necessary x-rays.

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

______________________________ ______________________________

Signature of Patient/Legal Guardian Date S. Jason Pavlik, DMD Date