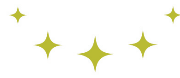

signature orthodontics

Setareh Mozafari , DDS

Tell Us About Your Child

Today's Date ____/____/_____ Male Female

Child's Name: ______________________________
Nickname: ____________________ SS#: ______________________
Child's birthdate: ______/______/______ Child's Age: ___________
School: ______________________________ Grade: _____________
Hobbies/Sports: ____
Child's Home #: (_________)______________________________
Child's Home Address: ________________________________
____
General Dentist: ____
Dentist Phone Number:_____________________________________
Last Visit Date: ____

Who is Accompanying Your Child Today?

Name: __________________________ Relation: ______________
Do you have legal custody of this child? Yes / No
Whom may we thank for referring you? _________________
____
List brothers/sisters with age: __________________________
____
Parent's Marital Status:
Single Widowed Married
Divorced Separated

Mother's Information: Stepmother Guardian

Name: ______________________ Birthdate: ____/____/____
Work #: (___________) _______________________ Ext: _________
Home #: (____________) _________________________________
Cell#: (___________) ____________________________________
Job Title: ____
SS#: ____
E-mail Address: ____

Father's Information: Stepfather Guardian

Name: ______________________ Birthdate: ____/____/____
Work #: (___________) _______________________ Ext: _________
Home #: (____________) _________________________________
Cell#: (___________) ____________________________________
How Long at Current Job: _________________________________
Job Title: ____
SS#: ____
E-mail Address: ____

Person Responsible for Account

Name: _____________________________ Relation: ______________
Billing Address: ____
____
Previous Address: ____
____
Hm #: (_______) ______________ Cell #: (______) _____________
Employer: ____
Work #: (_________) _______________________ Ext: ___________
SS#: ____

Who is responsible for making appointments?
Name: ____
Work #: (_________) ______________________ Ext: ____________
Home #: (_________) ____

Neighbor or Relative not living with you
Name: ____
Phone #: ____
Address: ____
____

Primary Insurance

Dental Coverage? Yes / No Ortho Coverage? Yes / No
Insurance Co. Name: ____
Insurance Co. Address: _____________________________________
____
Group # (Plan, Local, or Policy #): ________________________
Policy Owner's Name: ___________________________________
Relationship to Patient: ___________________________________
Policy Owner's Birthdate: ____/____/____ SS#: __________
Policy Owner's Employer: _______________________________

Secondary Insurance

Dental Coverage? Yes / No Ortho Coverage? Yes / No
Insurance Co. Name: ____
Insurance Co. Address: _____________________________________
____
Group # (Plan, Local, or Policy #): ________________________
Policy Owner's Name: ___________________________________
Relationship to Patient: ___________________________________
Policy Owner's Birthdate: ____/____/____ SS#: __________
Policy Owner's Employer: _______________________________

signature orthodontics

Setareh Mozafari , DDS

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 the care of a physician? Yes / No
Has puberty begun? Yes / No
Has menstruation begun? (Girls) ? Yes / No
Has your child ever taken Phen-Fen? Yes / No
(Also known as Redux or Pondimin) If Yes, when? ____________

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: ______________
____

Has your child ever had any of the following medical problems?

Y / N Abnormal bleeding
Y / N ADD/ADHD
Y / N Allergies to any Drugs
Y / N Allergic to Latex/Metals
Y / N Allergic to Plastic
Y / N Any Hospital Stays
Y / N Any Operations
Y / N Artificial bones/Joints/ Valves
Y / N Asthma
Y / N Cancer
Y / N Congenital Heart Defect
Y / N Convulsions/Epilepsy
Y / N Diabetes
Y / N Handicaps/Disabilities
Y / N Hearing Impairment
Y / N Heart Murmur
Y / N Hemophilia
Y / N Hepatitis
Y / N HIV+/AIDS
Y / N Kidney Problems
Y / N Rheumatic/Scarlet Fever
Y / N Sickle Cell Disease
Y / N Tuberculosis (TB)

Please discuss any medical problems that your child has had:
____
____
____

Does/did your child have any of the following habits?

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

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 in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of parent or guardian Date

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.

____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment. Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.
Initials: ____________ Date: __________

Doctor's Comments: ____
____