Milberg Orthodontics

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Tell Us About Your Child

Today's Date: _____

Child's Name: _____
First Middle Last (Prefers to be called)

Child's Home Address: _____

Birth Date: _____/_____/_____ Male ☐ Female ☐ Child's School: _____

After School Name: _____ Grade: _____

Child's Home #: _____ Hobbies, activities: _____

Previous/Present Dentist: _____ Previous/Present Oral Surgeon: _____

Last Date Seen by General Dentist: _____ Who may we thank for referring you?: _____

List Family Members that are currently in our practice: _____

Has either parent had Orthodontic Treatment? ☐Yes ☐No

Has your child had previous Orthodontic Treatment? ☐Yes ☐No

Does your child need to be premedicated for dental procedures? ☐Yes ☐No

What are your chief complaints you would like to discuss with the Doctor?: _____

_____

_____

Has your child ever had the following medical problems?

Y N Teeth Clenching/Grinding/Mouth Breathing	Y N Allergies to any drugs	Y N Autism/Special Need
Y N Operations/Hospital Stays	Y N Root Canal Treated Teeth	Y N Cancer
Y N Congenital Heart Defect	Y N Convulsions / Epilepsy	Y N Diabetes
Y N Mental Health/Depression/Eating Disorder	Y N Hearing Impairment	Y N Heart Murmur
Y N Hemophilia/Abnormal bleeding/Bruising	Y N Hepatitis/Jaundice/Liver Problems	Y N HIV/AIDS
Y N Kidney / Liver Problems	Y N Rheumatic / Scarlet Fever	Y N Tuberculosis (TB)
Y N Frequent Colds/Sore Throats/Ear Infections	Y N High/Low Blood Pressure	Y N Asthma
Y N Supernumerary(Extra)/Congenitally Missing	Y N Teeth Erupting Early/Late	Y N Canker/Cold Sores

Does the child have the following habits? If yes, till what age? _____

Y N Lip Sucking / Biting Y N Nail Biting Y N Nursing Bottle Habits Y N Thumb / Finger Sucking

Has the child had any injuries to the face, mouth, or teeth? ☐Yes ☐No If yes, please explain: _____

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that the child is allergic to: _____

How many times does the child brush his/her teeth daily? _____

How many times does the child floss his/her teeth daily? _____

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

*For Girls Only: Has your daughter started their menstrual cycle? Y N If yes approximate date: _____/_____

Responsible Party Information

Parent/Guardian A:_____ Title:☐Mr.☐Ms.☐Mrs.☐Dr. Occupation:_____
Contact #:_____ Relationship to patient:_____
Address (If different from patient)_____
Email:_____ SSN#:_____

Parent/Guardian B:_____ Title:☐Mr.☐Ms.☐Mrs.☐Dr. Occupation:_____
Contact #:_____ Relationship to patient:_____
Address (If different from patient)_____
Email:_____ SSN#:_____

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Is there more than one person financially responsible for this account? ☐Yes ☐No
* If there is more than one financial party will you require a split contract? ☐Yes ☐No
Which responsible party name should the contract be in? _____
If different from above, Billing address: _____

Primary Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:_____
Group # :_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's Birth Date: _____
SS#: _____
Policy Owner's Employer:_____

Secondary Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:_____
Group # :_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's Birth Date: _____
SS#: _____
Policy Owner's Employer:_____

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 history or medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature:_____Date:_____