PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Today's Date: ____/____/____

Patient's name: ____
Last First Middle

Address: ____
Street City Zip

Nickname:______________________ Birthdate: ____/____/____ Child's Age: ____ Male:___ Female: ___

School___________________________ Sports/Hobbies____

General Dentist: ____ Last Visit: ______________________________

Whom may we thank for referring you to our office? ____

PARENT'S INFORMATION

Who is responsible for account? ______________________________________

Father: _____ Step Father: _____ Guardian: _____ Other: _____

Name: ____
Last First Middle

Address (If different than Child's): ____
Street City Zip

Birthdate: ___/___/___ Relationship to Patient:____

Home #:(____)_____________________ Work #: (____)_________________ Cell/other #:(____)_____________________

Email address: _________________________Employer:___________________________Occupation:____________________

Mother: _____ Step Mother: _____ Guardian:_____ Other: _____

Name: ____
Last First Middle

Address (If different than Child's): ____
Street City Zip

Birthdate: ___/___/___ Relationship to Patient:____

Home #:(____)_____________________ Work #: (____)_________________ Cell/other #:(____)_____________________

Email address: ________________________Employer:_____________________________Occupation:____________________

DENTAL INSURANCE INFORMATION

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

Insured Name: ____

Insurance Company:_________________________ Group # (Plan, Local, or Policy #):_________________________

Insurance Co. Address:____ Phone #: (___)____________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Company:_________________________ Group # (Plan, Local, or Policy #): _________________

Insurance Co. Address____ Phone #: (___)______________________

I understand that, where appropriate, credit bureau reports may be obtained.

Signature ____

EMERGENCY INFORMATION

Name:_______________________________________ Relationship to you:____

Complete address ____
Street City Zip

Phone #: (___)______________________

MEDICAL HISTORY

Physician ____ Date of Last Visit ____________________________
Address ____ Phone ____________________________________

Has the child ever had 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)

Are there any medical conditions we have not discussed that you feel we should be aware of? ________________________
____
Are your child's immunizations current? Yes or No
Has puberty begun? Yes or No
GIRLS:
Has menstruation begun? Yes or No   If yes, please provide date (for growth potential estimation):_______________________
Are you pregnant? Yes or No

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: Yes or No   **Nickel/Metals: Yes or No**   **Plastic: Yes or No**

DENTAL HISTORY

General Dentist:____ Date of last visit: ____________________________
What are the main concerns that you would like orthodontics to accomplish?
____
____

Has your child ever been evaluated or has orthodontic treatment before?	___ YES	___NO
Does the child brush teeth daily?	___ YES	___ NO
Floss teeth daily?	___ YES	___ NO
Have adenoids or tonsils been removed?	___ YES	___ NO
Does the child require antibiotics before dental treatment?	___ YES	___ NO
Is the patient sensitive or self-conscious about his/her teeth?	___ YES	___ NO

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

Y	N	Clenching/Grinding Teeth	Y	N	Speech Habit
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Pacifier

Has patient ever experienced the following?

Y	N	Injures to face, mouth, teeth or chin	Y	N	Pain/Tenderness in jaw joint (TMJ)
Y	N	Jaw clicking or popping	Y	N	Tension headaches

PARROTT ORTHODONTICS

Quay William Parrott III, DDS, MS, PLC
1115 Ivy Street, Waynesboro, VA 22980
Phone (540) 949-6600

PRIVACY CONSENT

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.

This form is optional under the new patient regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form.

You have the right to review our office's privacy notice prior to signing this Consent, at your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of changes, and the changes may not be implemented prior to the effective date of the provision notice.

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.

I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. ____________________ to perform a complete orthodontic evaluation.

Date:____/____/____

Parent/Guardian Signature: ____

Print Patient Name:____