

Child Information Form



Douglas H. Rediger, DDS, PC
Specialist in Orthodontics for Adults & Children

WELCOME!

To assist us in providing the most complete service, please provide the following information and health history.

Date _____

PATIENT INFORMATION

Patient _____ Nickname _____

First Middle Last

Sex _____ Age _____ Date of Birth _____ School _____ Grade _____

MO. DAY YR.

Dentist _____ Dentist Phone# () _____

Referred by _____

Brothers/Sisters/(Name and Age) _____

Have any of the patient's relatives been treated in our office? yes no Who and When _____

Mother:

Father:

Name _____ Name _____

Address _____ Address _____

(If different)

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home phone _____ Home phone _____

Mobile phone _____ Mobile phone _____

Employed by _____ Employed by _____

Work phone _____ Work phone _____

Marital Status _____ Marital Status _____

Parent's email address _____ Parent's email address _____

Person Responsible For Financial Arrangements on the Account _____

How would you prefer we confirm your appointments? email phone text message

PRIMARY DENTAL INSURANCE ONLY

SECONDARY DENTAL INSURANCE ONLY

Orthodontic coverage? Yes No (If "Yes" complete below)

Orthodontic coverage? Yes No (If "Yes" complete below)

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Insurance Co. Phone #: () _____

Insurance Co. Phone #: () _____

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

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

Policy Holder's Name: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Policy Holder's Birthdate: / / SS#: _____

Policy Holder's Birthdate: / / SS#: _____

Policy Holder's Employer: _____

Policy Holder's Employer: _____

FOR OFFICE USE ONLY

Insurance Verification

Account # _____

Financial Agreement: Fee _____

Date: _____ Lifetime Max _____ Used to date? _____

Payment Plan: _____

Effect Date: _____ How to bill: Mos _____ Qtr. _____ 6 mos _____ Annual _____

Contract Signed: _____

Deductable: _____ Payer I.D. _____

Coupons Printed: _____

Insurance Billed: _____

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Please check box if patient has or has had:

- | | |
|--|--|
| <input type="checkbox"/> Positive HIV Test | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> Earaches |

Does the patient require premedication for dental procedures? Yes No

List any other serious illnesses:

List any allergies including latex or metal:

List drugs or medications now being taken:

Is patient under physician's care presently? _____

Reason: _____

Name of physician: _____

Additional comments: _____

Please note any other factors that Dr. Rediger should be aware of regarding the patient's dental health: _____

DENTAL HISTORY

Please check box if answer is yes:

- Any injuries to face, mouth, teeth? (circle)
- Thumb, finger, lip sucking? (circle)
- Mouth-breathing when asleep, awake? (circle)
- More than average amount of decay?
- Any missing permanent teeth?
- Any extra permanent teeth?
- Any teeth removed by extraction?
- Is there any tongue-thrusting problem?
- Any speech problems?
- Any difficulty in swallowing or chewing?
- Any pain or clicking on opening mouth?
- Is patient adopted? _____
- Does the patient visit the dentist regularly?
Date of last dental visit _____
- Has an orthodontist been consulted previously?
Reason: _____

List any wind instrument played:

Sports: _____

ORTHODONTIC CONCERNS

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.)

Please describe your reasons for considering orthodontic treatment.

- Improved facial appearance
- Improved functional health
- Enhanced long-term dental health
- Other _____

Please describe your child's attitude toward orthodontic treatment.

- Wants it done
- Does not want it done
- Does not care

PATIENT AUTHORIZATION - PLEASE SIGN BELOW

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 or insurance status.

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 the office, use the services of one or more credit reporting services.

X

Signature of parent or guardian Date

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

X

Signature of parent or guardian Date

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.

X

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.