

# Child Information Form



WELCOME

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

Date \_\_\_\_\_

## PERSONAL INFORMATION

Name \_\_\_\_\_  
First Middle Last Nickname \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
MO. DAY YR.

Brothers/Sisters (Name and Age) \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Referred by \_\_\_\_\_

**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 \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

Marital Status \_\_\_\_\_ Marital Status \_\_\_\_\_

Parent's email address \_\_\_\_\_ Parent's email address \_\_\_\_\_

Person Responsible For Account \_\_\_\_\_

### PRIMARY DENTAL INSURANCE ONLY

Ortho coverage?  Yes  No If "Yes" complete below

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

### SECONDARY DENTAL INSURANCE ONLY

Ortho coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

### FOR OFFICE USE ONLY

Insurance Verification \_\_\_\_\_ Lifetime Max \_\_\_\_\_ How much Met? \_\_\_\_\_ Claim Address: \_\_\_\_\_

Date: \_\_\_\_\_ How to bill: Mos \_\_\_\_\_ Qtr. \_\_\_\_\_ 6 mos \_\_\_\_\_ Annual \_\_\_\_\_

Effect Date: \_\_\_\_\_ Payer I.D. \_\_\_\_\_

Ded.: \_\_\_\_\_ Carrier # \_\_\_\_\_

Brett J. Hill, DDS, MS  
9615 Caldwell Commons Circle, Suite A  
Cornelius, NC 28031  
(P) 704.896.8452 (F) 704.896.8124

**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            |

List any other serious illnesses:

\_\_\_\_\_

List any allergies:

\_\_\_\_\_

List drugs or medications now being taken:

\_\_\_\_\_

Is patient under physician's care presently? \_\_\_\_\_

Reason: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Approximately how much has patient grown in the last year? \_\_\_\_\_

Additional comments: \_\_\_\_\_

Please note any other factors the doctor should know about the patient's dental health:

\_\_\_\_\_

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 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

## 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? At what age? \_\_\_\_\_
- Does patient visit dentist regularly?

Date of last dental visit: \_\_\_\_\_

Has an orthodontist been consulted previously?

Reason: \_\_\_\_\_

List any wind instrument played:

\_\_\_\_\_

Sports: \_\_\_\_\_

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.