**PATIENT INFORMATION**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Name child goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_ Age: \_\_\_ Sex: \_\_\_M \_\_F SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_\_**

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_**

**Name and ages of other children in family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If patient is a minor, parent or guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who has legal custody of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insurance Policy Holder: \_\_\_Yes \_\_\_No**

**Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY INFORMATION**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_   
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_   
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION**

**Insured’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_**

**Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy #\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insured’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

**Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insured’s Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE INFORMATION** (if applicable)

**Insured’s Name (Full Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insured’s SSN: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_**

**Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Group/Policy #\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY INFORMATION**

**Name of Emergency Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CIRCLE Yes or No (If Yes, please fill in details.)**

**Yes No Is your child in good health?   
Yes No Has your child ever had a health problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Has your child ever been hospitalized or had any major operations? If Yes, please give reason and date/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Were there any problems at birth?   
If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Is your child taking any medications? Please give medication name, dose and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Is your child allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Has your child ever been involved in a serious accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE MARK if your child has or has been treated for any of the medical conditions/health issues and elaborate below:**

|  |  |  |
| --- | --- | --- |
| **\_\_Abnormal Bleeding**  **\_\_ADD/ADHD**  **\_\_Adverse Drug Reactions**  **\_\_Anemia**  **\_\_Arthritis**  **\_\_Asthma/Hay Fever**  **\_\_Autism**  **\_\_Bleeding/Transfusions**  **\_\_Blood Disorder**  **\_\_Bone Disorders**  **\_\_Cancer/Tumor**  **\_\_Cerebral Palsy**  **\_\_Cleft lip/palate**  **\_\_Congenital Heart Defect**  **\_\_Diabetes** | **\_\_Dizziness**  **\_\_Endocrine/Growth**  **\_\_Epilepsy**  **\_\_Eyesight**  **\_\_Frequent Infections**  **\_\_GI Disorders**  **\_\_Heart Problems**  **\_\_Hepatitis**  **\_\_Heart Disease**  **\_\_Heart Murmur**  **\_\_HIV/Aids**  **\_\_High Blood Pressure**  **\_\_Kidney Problems/Disease**  **\_\_Herpes**  **\_\_Liver Problems** | **\_\_Mental Delays \_\_Neuromuscular Disorder**  **\_\_Nervous Problems**  **\_\_Personality/Social**  **\_\_Physical Delays**  **\_\_Pneumonia**  **\_\_Recurrent Headaches**  **\_\_Rheumatic Fever**  **\_\_Prolonged Bleeding**  **\_\_Radiation/Chemotherapy**  **\_\_Seizures**  **\_\_Sickle Cell Disease/Trait**  **\_\_Significant Injuries**  **\_\_Speech/Hearing** |

**Details on any checked item:**

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

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

**Are there any other medical conditions not listed that we should be aware of?**

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

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

**DENTAL HISTORY**

**Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of last x-rays (if taken): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PEDIATRIC DENTAL HISTORY―**

**PLEASE CIRCLE Yes or No (If Yes, please fill in details.)**

**Yes No Has your child experienced any unfavorable reaction from previous dental care?**

**Yes No Does your child suck a finger, thumb, or pacifier?**

**Yes No Does your child have pain with chewing, yawning, or opening of his/her mouth?**

**Yes No Does your child’s jaw make noise and is pain associated with the sounds?**

**Yes No Is your child presently experiencing any dental pain? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Has your child ever lost or chipped any teeth?**

**Yes No Have there been any injuries to your child’s mouth or teeth?   
Yes No Is any part of your child’s mouth sensitive to temperature or pressure?**

**Yes No Do your child’s gums bleed when they brush?**

**Yes No Does your child have any type of thumb or tongue habit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Is your child a mouth breather?**

**Yes No Has your child ever seen an orthodontist?   
  
What concerns you most about your child’s teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION & RELEASE**

* **I have read and answered the above questions to the best of my knowledge.**
* **I authorize my insurance company to pay Chester County Orthodontics all insurance benefits otherwise payable to me for services rendered.**
* **I authorize the use of this signature on all insurance submissions.**
* **I authorize Chester County Orthodontics to release all information necessary to secure the payment of benefits.**
* **I understand that I am financially responsible for all charges whether or not paid by insurance.**

**Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**PARENTAL PERMISSION TO CONSENT**

**Please provide the names of any persons whom you consent to bring your child to dental appointments. Keep in mind that this person will be able to consent for treatment and will be financially responsible for any payments on that day of service.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTO &VIDEO RELEASE**

**I hereby give permission for images of my child captured during any/all Chester County Orthodontics visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Chester County Orthodontics; promotional material and publications and waive any rights of compensation or ownership thereto.**

**Name of Participant (Please print.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Parent/Guardian (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**