DOCTOR SMILES
orthodontics

Dr. Marisela Bedoya, DMD, DHSc

CHILD PATIENT INFORMATION

Date:

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home phone _____ Cell phone _____ Email _____

Male ☐ Female ☐ Date of Birth _____ Age _____ SSN _____

Nickname _____ School _____ Grade _____

Hobbies/Interests _____ Sports _____

Parents' marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Who will be responsible for the account? Mother ☐ Father ☐ Both ☐ Other ☐

If both, will it be equal responsibility? Yes ☐ No ☐ If other, who will be responsible? _____

If no, please explain _____

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

List any family members or friends that have been treated in this office _____

MOTHER'S INFORMATION

Name _____ Mother ☐ Stepmother ☐ Guardian ☐
Last First Middle

Address _____
Street City State Zip

Home phone _____ Cell phone _____ Work phone _____

Date of Birth _____ SSN _____ Email _____

Employer _____ Employer's Address _____ Occupation _____

If you have orthodontic insurance coverage for this child, please fill out.

Insurance Company Name _____ Policy/Group # _____

Insurance Company Phone _____ Insurance Company Address _____

I hereby authorize the release of any information relating to this claim and authorize payment of insurance benefits directly to Doctor Smiles Orthodontics.

_____ _____
Insured's Signature Date

FATHER'S INFORMATION

Name _____ Father ☐ Stepfather ☐ Guardian ☐
Last First Middle

Address _____
Street City State Zip

Home phone _____ Cell phone _____ Work phone _____

Date of Birth _____ SSN _____ Email _____

Employer _____ Employer's Address _____ Occupation _____

If you have orthodontic insurance coverage for this child, please fill out.

Insurance Company Name _____ Policy/Group # _____

Insurance Company Phone _____ Insurance Company Address _____

I hereby authorize the release of any information relating to this claim and authorize payment of insurance benefits directly to Doctor Smiles Orthodontics.

_____ _____
Insured's Signature Date

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Is your child taking any medications? Yes ☐ No ☐ If yes, please list _____

Is your child in good health? Yes ☐ No ☐

Does your child have a history of any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Abnormal bleeding	☐	☐	Cancer	☐	☐	Kidney disorders	☐	☐	Seasonal allergies	☐	☐
ADD/ADHD	☐	☐	Craniofacial syndromes	☐	☐	Lung disorders	☐	☐	Sinus problems	☐	☐
AIDS/HIV	☐	☐	Diabetes	☐	☐	Migraines	☐	☐	Surgery	☐	☐
Anemia	☐	☐	Difficulty breathing	☐	☐	Mitral valve problems	☐	☐	Thyroid problems	☐	☐
Arthritis	☐	☐	Drug/alcohol abuse	☐	☐	Orofacial clefts	☐	☐	Tuberculosis	☐	☐
Artificial joints/valves	☐	☐	Epilepsy/seizures	☐	☐	Psychiatric problems	☐	☐	Ulcers/colitis	☐	☐
Asthma	☐	☐	Heart disorders	☐	☐	Radiation treatment	☐	☐	Vision/hearing	☐	☐
Blood disorders	☐	☐	Hepatitis	☐	☐	Rheumatic fever	☐	☐	Other	☐	☐
Blood transfusions	☐	☐	Hospitalization	☐	☐	Scarlet fever	☐	☐			

Please explain any "yes" responses _____

Please list any other medical alerts _____

Have adenoids and/or tonsils been removed? Yes ☐ No ☐ If yes, when? _____

Girls Only:	Yes	No
Has menstruation begun?	☐	☐
If yes, when _____		
Are you pregnant?	☐	☐
If yes, how far along _____		

Has puberty begun? Yes ☐ No ☐

Is your child allergic to any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Anesthetics	☐	☐	Cyclosporins	☐	☐	Latex	☐	☐	Sulfa drugs	☐	☐
Amoxicillin	☐	☐	Codeine	☐	☐	Metal	☐	☐	Tetracycline	☐	☐
Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Other	☐	☐

Please list any other drugs or material your child may be allergic to _____

DENTAL HISTORY

Dentist's Name _____ Date of last visit _____

What concerns you most about your child's teeth? _____

Does your child have a history of any of the following?

	Yes	No		Yes	No		Yes	No
Complication following dental treatment	☐	☐	Injury to teeth	☐	☐	Suck fingers or thumb	☐	☐
Dental problems	☐	☐	Jaw clicking/popping	☐	☐	Toothaches or cavities	☐	☐
Grind/clench teeth	☐	☐	Jaw pain	☐	☐	Use of fluoride products	☐	☐
Injury to face or jaw	☐	☐	Mouth breathing	☐	☐	Other	☐	☐

Please explain any "yes" responses _____

Please list any other dental alerts _____

Does your child need pre-medication before dental treatment? Yes ☐ No ☐

Realizing that successful treatment greatly depends upon the patient's cooperation in following instructions, keeping appointments, and maintaining good oral hygiene. Are there any restrictions, handicaps, or problems that might be encountered during treatment? Yes ☐ No ☐
If yes, please explain _____

I certify that the information in this form is true and correct to the best of my knowledge. I will notify this practice should there be any future changes in the patient's medical or dental status.

_____ _____ _____

Signature of person completing this form | Relationship to patient | Date