CHILD PATIENT INFORMATION

Haltom Orthodontics

Creating World Class Smiles

Date: _____

GETTING TO KNOW YOUR CHILD...

Name: _____ Nickname: _____ Birthdate: _____ - _____ - _____

Home Address: _____ SSN: _____ - _____ - _____ Sex: _____

City/State/Zip: _____ School & Grade: _____

Sibling Names & Ages: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

WHAT ARE YOUR GOALS?

If you could change anything about your child's smile or bite, what would it be? _____

How long have you wanted to have this changed? _____

What factors have been standing in your way? _____

Does your child have concerns about undergoing orthodontic treatment? _____

Has anyone in your family had braces with us before? Please list: _____

Who can we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name: _____ Nickname: _____ Birthdate: _____ - _____ - _____

Home Address: _____ City/State/Zip: _____

How long at this address: _____ Previous address (if less than 3 years): _____

Mailing Address: _____ City/State/Zip: _____

Email Address: _____ Relationship to patient: _____ SSN: _____ - _____ - _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Years Employed: _____

Spouse's Name: _____ SSN: _____ - _____ - _____ Birthdate: _____ - _____ - _____

Employer: _____ Occupation: _____ Years Employed: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Policy Holder: _____ SSN: _____ - _____ - _____ Birthdate: _____ - _____ - _____

Policy Holder's Employer: _____ Group No: _____

Insurance Company: _____ Subscriber ID: _____

Insurance Company Address: _____ Insurance Company Phone: _____

Do you have dual coverage Y N If yes, complete the following:

Policy Holder: _____ SSN: _____ - _____ - _____ Birthdate: _____ - _____ - _____

Policy Holder's Employer: _____ Group No: _____

Insurance Company: _____ Subscriber ID: _____

Insurance Company Address: _____ Insurance Company Phone: _____

EMERGENCY INFORMATION

Name of nearest relative NOT living with you: _____

Complete Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to you: _____

MEDICAL HISTORY

Is your child currently seeing a physician or taking medications? Y N

If yes, what diagnosis? _____

Is your child pregnant? Expected due date? _____ Y N

Is your child allergic to any medications? Y N

Please list with reaction: _____

Any known allergies to metals: Y N

Please list with reaction: _____

Suffer from frequent headaches? Y N

Describe any injuries to your child's face or teeth: _____

Has your child had or currently have any history of the following?

Arthritis	Y N	Heart Trouble	Y N	Swollen Glands	Y N	AIDS/HIV	Y N
Hepatitis	Y N	Ulcers	Y N	Cancer	Y N	Glaucoma	Y N
Bone Disorder	Y N	Neck/Shoulder Pain	Y N	Asthma	Y N	Psychiatric Treatment	Y N
Artificial Joint	Y N	Heart Murmur	Y N	Fainting/Seizures	Y N	Blood Disorder	Y N
Diabetes	Y N	Sinus Infection	Y N	High Blood Pressure	Y N	Liver Ailment	Y N
Herpes/Oral cold sores	Y N	Ear Disorder	Y N	Rheumatic Fever	Y N	Speech problems	Y N
Joint Swelling	Y N	Tuberculosis	Y N	Emotional Problems	Y N	Sleep Apnea	Y N

If yes, please describe: _____

Are there any medical issues not listed above? _____

If yes, please describe: _____

Physician Name: _____ Phone: _____ Last Exam Date: _____

DENTAL HISTORY

Dentist Name: _____ Phone: _____ Last Exam Date: _____

Dental treatment that needs to be completed prior to orthodontic treatment? Y N Scheduled date: _____

How often does your child brush their teeth each day? (Circle) Several times Twice Once Less Than Once

How often does your child floss their teeth each day? (Circle) Several times Twice Once Less Than Once

Has your child had or have any of the following habits? (Circle all that apply)

Lip Biting	Y N	Nail Biting	Y N	Thumb Sucking	Y N
Gum Chewing	Y N	Ice Chewing	Y N	Finger Sucking	Y N

Has your child ever experienced any of the following? (Circle all that apply)

Ear aches	Y N	Jaw clicking/popping	Y N	Jaw joint pain	Y N
Jaw locking	Y N	Facial muscle pain	Y N	Face tightness/sore	Y N
Clenching	Y N	Grinding	Y N	Painful chewing	Y N

Has your child ever been treated for any of the following? (Circle all that apply)

TMJ/TMD	Y N	Periodontal Disease	Y N	Bad Breath/Halitosis	Y N

Have you consulted with an orthodontist previously? Y N Whom/When? _____

If yes, what was it that caused you to seek another opinion? _____

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

I, the undersigned, give my permission for treatment from Dr. Haltom and his staff. I hereby authorize the taking of x-rays and other diagnostic records for an initial diagnosis if needed. I further acknowledge that the original diagnostic records are by State law, the property of the practice. I also give my approval and consent for the patient's name, photographs and other diagnostic material to be used in scientific, educational, and/or promotional work produced by Dr. Haltom and staff. I hereby authorize payment of insurance benefits directly to Darren Haltom, D.D.S., M.S. , for services rendered to the patient. I also authorize the release of all patient records or other information necessary to determine benefits payable and/or which may be used for claims data analysis. I authorize the use and disclosure of protected health information to complete treatment, payment activity, and Healthcare operations.

Signature: _____ Relationship to Patient: _____ Date: _____