

Ted Vossers, DDS, MS, PA
Child Orthodontic Patient Information

Date ___/___/___
Update ___/___/___

-Please Print-

Date of Birth ___/___/___

Patient Name _____ Sex _____ SS# _____

Home Address _____ Preferred Name _____

_____ Home Phone _____

Family Email Address _____ Cell Phone _____

Occupation/School _____ Employer/Grade _____ Work Phone _____

Hobbies/ Interests _____

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

Physician _____ Family Dentist _____ Last Dental Visit _____

Please list any family members treated here _____

Names & ages of brothers and sisters _____

Person responsible for payment of the account _____ Relationship _____

Orthodontic Insurance _____ Company Name _____

Parents are (circle one): Single Married Separated Divorced Widowed Other _____

Father's Name _____ SS# _____ D.O.B. _____

Address if different _____

Occupation _____ Employer _____ Business Phone _____

Cell# _____ Home# _____

Mother's Name _____ SS# _____ D.O.B. _____

Address if different _____

Occupation _____ Employer _____ Business Phone _____

Cell# _____ Home# _____

Emergency Contact If parents can't be reached _____ Phone _____

MEDICAL HISTORY

Yes No Any major or unusual illnesses?

Explain _____

Yes No Currently under physician's care?

Reason _____

Yes No Have taken or are taking Bisphosphonates(ex: Fosomax)?

How long ago? _____

Yes No Currently taking medication?

List _____

Yes No Any drug allergies/sensitivities?

List _____

Please turn over to back of page

MEDICAL HISTORY CONTINUED

Yes No PreMed for Dental Treatment Yes No Joint Replacement
Yes No Heart Murmur Yes No Hepatitis/Liver Disease Yes No Speech/ Hearing Problems
Yes No Rheumatic Fever Yes No Heart Trouble Yes No Allergies
Yes No Epilepsy Yes No High Blood Pressure Yes No Diabetes
Yes No Fainting/Dizziness Yes No Cold Sores/ Herpes Yes No Frequent Colds/Flu
Yes No Asthma Yes No AIDS Antibody Positive Yes No Tonsilitis/ Adenitis
Yes No Glaucoma Yes No Abnormal Bleeding Yes No Tonsils/ Adenoids Removed
Yes No Contact Lenses Yes No Frequent Headaches Yes No Tuberculosis

GROWTH INFORMATION (Patients under 16)

Father's Height _____ Mother's Height _____ Patient resembles: Father __ Mother __ Neither __ Adopted __

Any recent growth? _____ When and how much ? _____

Girls: Has she started menstruation? Yes No When? _____

Boys: Has his voice changed? Yes No When? _____

DENTAL HISTORY

Yes No Any injuries to the face, mouth, or teeth?
Explain _____

Yes No Has the patient ever sucked a thumb or finger? Until what
age? _____

Yes No Any history of jaw joint soreness, clicking, or
popping? _____

Yes No Any history of clenching or grinding of
teeth? _____

Yes No Has an orthodontist been consulted previously?
When? _____

Yes No Has the patient had any previous orthodontic treatment?
When? _____

Why are you seeking orthodontic consultation? (What is your main concern?) _____

Any additional information which you feel would help make your association with us more enjoyable.

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper orthodontic care.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment to my dentist and/or referred specialist.

I hereby authorize payment of insurance benefits directly to Ted Vossers, DDS, MS, PA otherwise payable to me.

I understand that my orthodontic care insurance carrier or payor of my orthodontic benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

Patient's or Guardian's Signature _____ Date _____

Reviewed
By _____ Date _____

